Exhibit 3

Part 2

- Presentations to various Behavioral Health providers and provider organizations at state, regional, and local levels to deliver education and clarification on reporting procedures and implementation of the Communication Assessment Report recommendations.

Increase Access to Community Mental Health Services

DBHDD has worked to assure uniformity of services throughout the state and to increase availability of community services particularly in rural areas by developing models such as Community Support Team, Mobile Crisis, Behavioral Health Crisis Centers and expanding the use of Peer Support across service modalities. DBHDD continues to focus on increasing access to community mental health services for adults with SMI.

There are mobile crisis teams in all six regions. As Georgia enhances community integration options for persons living with a diagnosis of a major mental illness, mobile crisis response services fulfill an important role in stabilizing and supporting persons in crisis while assisting them in choosing the right environment to overcome that crisis. DBHDD continues to look at specialized models for mobile crisis, particularly to address individuals with co-occurring mental health and developmental disabilities.

Telemedicine continues to be an emerging avenue for dealing with the shortage of physicians and other practitioners in rural areas and Georgia is exploring additional ways to promote the effective use of telemedicine into the system of care. There are over 60 DBHDD provider sites that are participating in the Global Partnership for Tele-Health. In addition, DBHDD is working with DCH to implement a phased in approach to tele-mental health services. Effective October 1, 2017, the state implemented policy which allows all behavioral health services to be provided via telemedicine for non-English speaking individuals accessing services delivered by a practitioner who speaks his/her language (includes American Sign Language). Also, LPCs and LMFTs have been added as practitioners who can provide diagnosis and assessment.

PATH funded services provide a statewide strategy to strengthen outreach and engagement activities designed to target the chronically homeless population. DBHDD values the team approach to case management and promotes outreach teams that go into the street, shelters and familiar homeless gathering locations. Peer Specialists with homeless experience are integral members of the teams, bringing their unique contributions that promote dignity, respect, acceptance, integration, and choice.

In the 2020 MHBG application, DBHDD has developed a priority area focused on access to community mental health services. The plan focuses on mobile crisis services, PATH services and tele-mental health services.

Increase Training to Providers

With the goal to help adults with SMI to attain and maintain recovery in their lives, it is necessary to provide training that will support the ability of providers and key partners to deliver services and supports needed. With DBHDD moving toward a recovery-oriented system of care, it is necessary to continue to provide opportunities for providers to understand recovery focused service delivery. In addition, providers have diverse populations to serve and need training on working with specific populations such as

veterans and individuals from the LGBT community. DBHDD has also noted an increase in the ethnic and racial diversity of the state and of the consumers served by DBHDD providers. There is a need to enhance the availability of trainings to assist providers with becoming more culturally competent to better meet the needs of the populations to be served.

DBHDD trains key partners in Mental Health First Aid (MHFA) as a strategy to promote consumer success in housing arrangements and Supported Employment. This training teaches first responders about mental illness and how to manage an emerging mental health crisis.

DBHDD has established a priority area of provision of diverse training to community adult mental health providers. The goal is to increase access to training focused on supporting the behavioral health of diverse populations of adults with SMI. The training topics will include: recovery focused service delivery; cultural and linguistic competency; behavioral health needs of veterans; behavioral health needs of those with criminal history; behavioral health needs of LGBT individuals; and, Mental Health First Aid.

CHILD AND ADOLESCENT MENTAL HEALTH – UNMET NEED

Based on the US Census Bureau, in 2018 Georgia was estimated to have a population of 10,519,475. Children and adolescents under the age of 18 represent 23.8% of the population. When the Annie E. Casey Foundation released its first ever KIDS COUNT state rankings of child and family well-being in 1990, Georgia ranked 48th. The Foundation's 2019 rankings show that Georgia has made significant gains in three of four KIDS COUNT domains – education, health, family and community. Georgia ranked 38th in overall child well-being, 34th in education, 34th in health, and 38th in family and community. However, the state ranks 40th in economic well-being with 28% of the state's children living in homes where no parent had full-time employment. Further, more than 21% (500,000 children) of Georgia's children live in poverty; a rate higher than it was in 1990. However, in 1990 13% of the state's children did not have health insurance coverage compared to 7% today.

Seven percent (an improvement from 10% in 2010) of Georgia's children do not have health insurance compared to 5% nationally. Approximately 221,000 children in the state lack insurance coverage. Georgia's Medicaid program provides health care for 1.82 million children, pregnant women and people who are aged, blind and disabled. The Department of Community Health administers the state's Medicaid and PeachCare for Kids State Child Health Insurance (CHIP) programs. Fifty-two percent (1,443,084) of Georgia's children 19 and under are covered by Medicaid or PeachCare for Kids. Almost 53% of the DCH budget is for Aged, Blind and Disabled (ABD) Medicaid and approximately 44% of the budget is for low-income Medicaid and 3% is for PeachCare for Kids. To qualify for PeachCare, the children must live in a home where the income is at or below 235% of the Federal Poverty level.

Georgia currently serves a monthly average of 1,862,573 Medicaid members (estimated 65% are children) and 127,975 Children's Health Insurance Plan members under PeachCare for Kids. Medicaid eligibility requirements allow for coverage for low income families, pregnant women, children and specified aged, blind, and disabled citizens. Under current eligibility

requirements single childless adults do not have access to Medicaid benefits.

In the Mental Health America Report, *The State of Mental Health in America 2019*, Georgia is ranked 21st compared to other states based on 15 measures of which 7 are related to child and adolescent mental health. These seven measures and their rankings are:

1. Youth with at least one past year major depressive episode (MDE)- 2nde (2017-8th)
2. Youth with dependence or abuse of illicit drugs or alcohol- 3rd (2017-13th)
3. Youth with severe MDE- 4th (2017-2nd)
4. Youth with MDE who did not receive mental health services- 16th (2017 -28th)
5. Youth with severe MDE who received some consistent treatment- 48th (2017-47th)
6. Children with private insurance that did not cover mental or emotional problems- 32nd (2017-38th)
7. Students identified with emotional disturbance for an Individualize Education Program – 28th (2017-24th)

States with high rankings have lower prevalence of mental illness and higher rates of access to care for youth. Lower rankings indicate that youth have higher prevalence of mental illness and lower rates of access to care.

Additional information related to mental health issues of youth in Georgia, is in the Behavioral Health Barometer, Georgia 2015 Report. In this report, the following is cited:

- An annual average of about 85,000 adolescents aged 12-17 in 2014-2015 had experienced a Major Depressive Episode (MDE) in the past year.
- An annual average of about 27,000 adolescents (40.3%) aged 12-17 with past year MDE from 2011-2015 received treatment for their depression in the past year.
- In 2015, 19,657 children and adolescents were served in Georgia's public mental health system. 45.8% of adolescents reporting improved functioning. This percentage was lower in Georgia than in the nation as a whole.

DBHDD provides services to youth with SED and their families. Georgia has been using the federal definition of SED as part of the eligibility criteria for services. According to the Center for Disease Control and Prevention, one in five youth in the United States have mental health conditions. According to the U.S. Census figures for 2016, there are 2,515,730 children and adolescents 0-17 in Georgia. Applying 20% to this total would yield 503,146 youth in Georgia with a mental health condition.

Further, estimation methodologies recommended for youth with SED were provided by the Center for Mental Health Services. These estimation methodologies identified two prevalence estimates, one of 5% - 9% for youth with SED and extreme functional impairment and one of 9%-13% for youth with SED and substantial functional impairment. These estimates are only applied to the 9-17-year-old age group. No estimation methodology has been provided by CMHS for estimating prevalence of emotional disturbance in children birth through age 9.

According to the Uniform Reporting System Tables provided by CMHS, Georgia would utilize

the 7%-9% range for determining prevalence of youth with SED and extreme functional impairment and 11%-13% range for determining prevalence of youth with SED and substantial functional impairment. Applying this percentage to the 2015 child and adolescent population of 1,246,332 age 9-17 years old would yield a prevalence range of 87,243 to 112,170 for youth with SED and extreme impairment and a prevalence range of 137,097 to 162,023 for youth with SED and substantial impairment. Due to limited resources, Georgia is targeting the youth with SED and extreme impairment utilizing an 8% prevalence rate which yields a target of 99,707. In SFY2015, DBHDD served 15,662 youth aged 9-17. Using this data and applying the prevalence estimate, DBHDD reached 15.6% of the estimated need. With 200% poverty as a factor, the estimated number of youth needing services from the public sector is 46,463. Using this factor, DBHDD reached 33.5% of the estimated eligible need.

According to the Georgia URS Tables for the 12/1/2016 Report Submission, DBHDD served 17,385 children and adolescents in community mental health programs, constituting 12.2% of all those served. In addition, according to this report, DBHDD served 10,660 children and adolescents with SED ages 0-17. No children were served in state psychiatric hospitals. It is also important to note that DBHDD does not serve all SED youth in need of services. Most youth are currently served by the DCH/Division of Medicaid Assistance through Care Management Organizations (CMOs). They serve youth in their parent's custody who are Medicaid eligible and youth who are involved with DFCS (not foster care) or committed DJJ youth who are Medicaid eligible. DBHDD serves uninsured youth, children receiving SSI and adoptive children whose families choose to opt out of the CMO. There are also youth with private insurance who receive services from private and public providers.

In SFY2016, 11,087 youth received Core Services. In addition, 1,235 youth received crisis stabilization unit (CSU) services; 10 youth received supported employment (SE) services, 881 children and adolescents received Intensive Family Intervention (IFI) services, and 198 (Medicaid only) received Psychiatric Residential Treatment Facility (PRTF) services. Since there are no longer child and adolescent state hospital units, DBHDD does not have state hospital admissions and readmissions data to report.

The most relevant strength of the DBHDD system is the development of the eligibility definition for child and adolescent mental health and addictive disease services. Because of growing pressure for services using the public dollar, it became imperative to identify those who are eligible to receive services, and the level of services to be offered. The following information on eligibility is included in the DBHDD 2018 Provider Manual. There are four variables for consideration to determine whether a youth qualifies as eligible for child and adolescent mental health and addictive disease services:

1. **Age:** A youth must be under the age of 18 years old. Youth aged 18-21 years (children still in high school or when it is otherwise developmentally/clinically indicated) may be served to assist with transitioning to adult services.

2. **Diagnostic Evaluation:** The DBHDD system utilizes the Diagnostic and Statistical Manual of Mental Disorders (DSM) classification system to identify, evaluate and classify a youth's type, severity, frequency, duration and recurrence of symptoms. The diagnostic evaluation must yield information that supports an emotional disturbance and/or substance related disorder primary diagnosis (or diagnostic impression). The diagnostic evaluation must be documented adequately to support the diagnosis.
3. **Functional/Risk Assessment:** Information gathered to evaluate a child/adolescent's ability to function and cope on a day-to-day basis comprises the functional/risk assessment. This includes youth and family resource utilization and the youth's role performance, social and behavioral skills, cognitive skills, communication skills, personal strengths and adaptive skills, needs and risks as related to an emotional disturbance, substance related disorder or co-occurring disorder. The functional/risk assessment must yield information that supports a behavioral health diagnosis (or diagnostic impression) in accordance with the DSM.

4. **Financial Eligibility:** Established in DBHDD policy.

The following youth are priority for services:

1. The first priority group for services is Youth:
   - Who are at risk of out-of-home placements; and
   - Who are currently in a psychiatric facility or a community-based crisis residential service including a crisis stabilization unit.
2. The second priority group for services is:
   - Youth with a history of one or more hospital admissions for psychiatric/addictive disease reasons within the past 3 years;
   - Youth with a history of one or more crisis stabilization unit admissions within the past 3 years;
   - Youth with a history of enrollment on an Intensive Family Intervention team within the past 3 years;
   - Youth with court orders to receive services;
   - Youth under the correctional community supervision with mental illness or substance use disorder or dependence;
   - Youth released from secure custody (county/city jails, state YDCs/RYDCs, diversion programs, forensic inpatient units) with mental illness or substance use disorder or dependence;
   - Pregnant youth;
   - Youth who are homeless; **or,**
   - IV drug Users.

Data to support planning and to monitor service effectiveness is collected through several processes. The contracted ERO collects and reports consumer encounter data that includes information on consumer level of need and response to treatment. When originally developed, this ERO data was only generated for Medicaid eligible consumers. Under the existing ERO contract this data is collected and reported for all consumers in service within the public mental

health system, regardless of payer source. System evaluation information is collected with consumer surveys and clinical functional assessment tools. The consumer survey that is employed is administered by families and utilizes the questions of the national MHSIP survey. The clinical functional assessment data is collected through the ERO function.

As indicated previously, the DBHDD system of services is administered through six Field Offices. These offices administer the community resources assigned to the region. They oversee statewide initiatives; develop new services and expand existing services as needed; and, monitor the services being received by consumers to ensure quality and access. Service planning is unique to the needs of each community and includes significant input from community members and service recipients. These offices have established Regional Collaboratives in their regions with representatives from provider agencies, advocacy groups, and other key stakeholders. These RCCs provide valuable information to the Field Offices related to service delivery. In addition, the Field Offices work collaboratively with established Regional Advisory Councils. These Councils are composed of community citizens appointed by their county Commissioners. Additional data on gaps and services by DBHDD Regions has been reported in the 2017-2018 DBHDD Statewide and Regional Priorities and Key Strategies document developed by the DBHDD Statewide Leadership Council which is composed of the Chairs of the 6 Regional Advisory Councils along with the entire RAC membership. The recommendations in the report are the result of a 20- month comprehensive community input and priority process conducted across the state and within each region.

Below is demographic information on each region as well as information gathered through the RAC process above.

Region One

According to the most recent Comparison of Need to Consumers Served data from SFY2015, Region 1 had a child and adolescent population ages 9-17 of 336,391. Based on prevalence estimates there are approximately 26,911 youth with SED in Region 1. DBHDD providers in Region 1 served 2,927 youth age 9-17 in SFY15 meeting 10.9% of the overall need. Multiplying the figure by the percentage of persons having income at or below 200% of poverty, it is estimated that approximately 8,531 children with SED would need services from the public sector. In FY 16, DBHDD providers for Region 1 reached 34.3% of the estimated eligible youth needing services from the public sector.

Due to the State of Georgia's Department of Community Health (DCH) moving low income Medicaid populations and foster care, adoption assistance, and some youth in the juvenile justice system to Care Management Organizations (CMO's), the numbers served by providers through these organizations are not tracked by DBHDD. Penetrations rates in the child and adolescent population are estimated to be much higher if these numbers were included.

Region 1 has a total of 24 child and adolescent providers covering 31 counties in the northern part of the state; 5 Tier 1 (CCPs), 10 Tier 2 (CMPs), 2 Tier 2+, and 7 Tier 3 Specialty providers. Many providers operate in multiple counties and most of the providers provide a majority of their services in the community versus a traditional clinic-based setting. This assists families

with transportation issues and scheduling barriers to be able to access needed services in their own homes. In SFY16, 2,412 youth received core services (traditional outpatient services), 241 received CSU services, 291 received IFI services, 1 received SE services, and 90 (Medicaid only) received PRTF services. In addition to these services, youth have access to C&A Specialty Services; Mobile Crisis, Care Management Entities, MH Clubhouses, School-based Mental Health Services, and System of Care Supplemental Funds.

Some of the priority needs and key strategies related to child and adolescent mental health for Region 1 recommended in the 2017-2018 RAC Report are:

- Reduce inappropriate involvement in the justice system by persons with mental illness, intellectual/developmental disabilities, and /or substance abuse.
- Prevention/early intervention in elementary school populations.
- Training for first responders to improve responses to people in crisis.
- Improve access to and navigation of DBHDD services.
- Improve public understanding of the system and how to engage in services.
- Increase availability of peer supports to help people stay engaged in services.

Region Two

According to the most recent Comparison of Need to Consumers Served data from SFY2015, Region 2 had a child and adolescent population ages 9-17 of 151,656. Based on prevalence estimates there are approximately 12,132 youth with SED in Region 2. DBHDD providers in Region 2 served 2,124 youth age 9-17 in SFY15 meeting 17.5% of the overall need. Multiplying the figure by the percentage of persons having income at or below 200% of poverty, it is estimated that approximately 4,804 children with SED would need services from the public sector. In FY 16, DBHDD providers for Region 2 reached 44.2% of the estimated eligible youth needing services from the public sector.

Due to the State of Georgia's Department of Community Health (DCH) moving low income Medicaid populations and foster care, adoption assistance, and some youth in the juvenile justice system to Care Management Organizations (CMO's), the numbers served by providers through these organizations are not tracked by DBHDD. Penetrations rates in the child and adolescent population are estimated to be much higher if these numbers were included.

There are 18 child and adolescent providers serving 33 counties in Region 2: 5 Tier 1 (CCPs), 4 Tier 2 (CMPs), 6 Tier 3 Specialty providers and 1 CBAY provider. In addition to core services (traditional outpatient services), children, youth and their families have access to the following services: Mobile crisis, crisis stabilization units, structured residential supports, Care Management Entity services, Resiliency Support Clubhouses, Juvenile Mental Health Court, Psychiatric Residential Treatment Facilities and Inpatient Acute Psychiatric Treatment. In SFY16, 1,454 youth received core services, 272 received CSU services, 90 received IFI, and 15 (Medicaid only) received PRTF services.

Some of the priority needs and key strategies related to child and adolescent mental health for Region 2 recommended in the 2017-2018 RAC Report are:

- ❖ Improve coordination among state agencies including Department of Family and Children's Services, Social Security, Department of Aging, and DBHDD.
- ➢ Identify which state agencies work with the target population.
- ➢ Create memoranda of understanding between state departments
- ➢ Create work groups to create solutions to barriers.
- ➢ Educate the public on desired outcomes
- ❖ Develop a comprehensive data management system that identifies current provider availability along with current placement needs.
- ➢ Identify current providers and capacity.
- ➢ Use Beacon system to identify how many individuals are being served in various programs
- ➢ Create a triage system
- ➢ Create a communication map of services delivered by each provider and provide to key stakeholders

Region Three

According to the most recent Comparison of Need to Consumers Served data from SFY2015, Region 3 had a child and adolescent population ages 9-17 of 378,893. Based on prevalence estimates there are approximately 300,311 youth with SED in Region 3. DBHDD providers in Region 3 served 4,851 youth age 9-17 in SFY15 meeting 16% of the overall need. Multiplying the figure by the percentage of persons having income at or below 200% of poverty, it is estimated that approximately 10,003 children with SED would need services from the public sector. In FY 16, DBHDD providers for Region 3 reached 48.5% of the estimated eligible youth needing services from the public sector.

Due to the State of Georgia's Department of Community Health (DCH) moving low income Medicaid populations and foster care, adoption assistance, and some youth in the juvenile justice
system to Care Management Organizations (CMO's), the numbers served by providers through these organizations are not tracked by DBHDD. Penetration rates in the child and adolescent population are estimated to be much higher if these numbers were included.

There are 90 child and adolescent providers covering 6 counties in the metropolitan Atlanta area: 3 Tier 1 providers (CCPs), 63 Tier 2 providers (CMPs), 3 Tier 2+ providers and 21 Tier 3 Specialty providers. Other services provided are Intensive Family Intervention, structured residential supports, Resiliency Supports Clubhouses, school-based mental health services, CSU, Mobile Crisis, Care Management and PRTF. In FY16, 3,884 youth received core services, 321 received CSU services, 1 received Assertive Community Treatment services, 312 received IFI services, 1 received psychosocial rehabilitation services and 79 (Medicaid only) received PRTF services.

Some of the priority needs and key strategies related to child and adolescent mental health for Region 3 recommended in the 2017-2018 RAC Report are:

- ❖ Increase community awareness of DBHDD diagnosis and treatment services.
- ➢ To identify children and adolescents in need of services from DBHDD, place a mental health professional in all county and city schools in Region 3.

- ❖ Develop services that address the needs of children and adolescents with behavioral health, intellectual/developmental disabilities, and addictive diseases.
- ➢ Develop more in-school counseling for behavioral health, intellectual/developmental disabilities, and addictive diseases.
- ➢ Develop step-down treatment programs which are therapeutic but less intensive than a Psychiatric Residential Treatment Facility and a Crisis Stabilization Unit.
- ➢ Develop providers who deliver more quality and creative programming and care.

Region Four

According to the most recent Comparison of Need to Consumers Served data from SFY2015, Region 4 had a child and adolescent population ages 9-17 of 74,167. Based on prevalence estimates there are approximately 5,933 youth with SED in Region 4. DBHDD providers in Region 4 served 2,015 youth age 9-17 in SFY15 meeting 34% of the overall need. Multiplying the figure by the percentage of persons having income at or below 200% of poverty, it is estimated that approximately 2,818 children with SED would need services from the public sector. In FY 16, DBHDD providers for Region 4 reached 71.5% of the estimated eligible youth needing services from the public sector.

Due to the State of Georgia's Department of Community Health (DCH) moving low income Medicaid populations and foster care, adoption assistance, and some youth in the juvenile justice system to Care Management Organizations (CMO's), the numbers served by providers through these organizations are not tracked by DBHDD. Penetrations rates in the child and adolescent population are estimated to be much higher if these numbers were included.

Region 4 covers 24 counties in the far Southwest corner of Georgia, bordering Southeast Alabama and North Florida. There are 9 child and adolescent providers: 3 Tier 1 providers (CCPs), 2 Tier 2 providers (CMPs) and 1 Tier 3 Specialty provider. Services other than core available to children, adolescents and their families are resiliency support clubhouse, intensive family intervention services, mobile crisis, crisis stabilization unit, forensic residential and psychiatric residential treatment facilities. In FY16, 1,239 youth received core services, 113 received CSU services, 6 received IFI services and 6 received SE services.

Some of the priority needs and key strategies related to child and adolescent mental health for Region 4 recommended in the 2017-2018 RAC Report are:

- ❖ Increase the number of child and adolescent Behavioral Health/Addictive Diseases/Intellectual and Developmental Disabilities inpatient and crisis stabilization unit beds.
- ➢ Develop contracts with local hospitals for dedicated beds.
- ➢ Collect data on bed use.
- ➢ Create and fund local CSUs
- ➢ Collaborate with other child-serving agencies
- ❖ Expand early intervention/education/prevention to identify at risk children and adolescents for behavioral health, addictive diseases and intellectual/developmental disabilities.
- ➢ Collaborate with and utilize agencies, services, and programs already in the business of identifying at risk families and youth.

- Allocate funding and recruit dedicated staff to serve at-risk families and youth.
- Collect data on all aspects of early intervention, education and prevention.
- Redirect funds from IFI to early intervention and prevention services.
- Provide community education for families about early warning signs as well as how to access treatment.

Region Five

According to the most recent Comparison of Need to Consumers Served data from SFY2015, Region 5 had a child and adolescent population ages 9-17 of 128,260. Based on prevalence estimates there are approximately 10,261 youth with SED in Region 5. DBHDD providers in Region 5 served 1,874 youth age 9-17 in SFY15 meeting 18.3% of the overall need. Multiplying the figure by the percentage of persons having income at or below 200% of poverty, it is estimated that approximately 4,104 children with SED would need services from the public sector. In FY 16, DBHDD providers for Region 5 reached 45.7% of the estimated eligible youth needing services from the public sector.

Due to the State of Georgia's Department of Community Health (DCH) moving low income Medicaid populations and foster care, adoption assistance, and some youth in the juvenile justice system to Care Management Organizations (CMO's), the numbers served by providers through these organizations are not tracked by DBHDD. Penetrations rates in the child and adolescent population are estimated to be much higher if these numbers were included.

Region 5 is in the southeast corner of Georgia; it has a land mass of 15,128 square miles and covers 26% of the state. The region includes 34 counties. Overall population density for the region is significantly smaller than the density of the State of Georgia. There are 15 child and adolescent providers in the region: 4 Tier 1 providers (CCPs), 4 Tier 2 providers (CMPs) and 6 Tier 3 Specialty providers. Other than core services, children and adolescents in the region also have access to care management entity, resiliency supports clubhouse, mobile crisis, and crisis stabilization services as well as psychiatric residential treatment facility services. In FY16, 1,590 youth received core services, 103 received CSU services, 109 received IFI services, 2 received SE and 24 (Medicaid only) received PRTF services.

Some of the priority needs and key strategies related to child and adolescent mental health for Region 5 recommended in the 2017-2018 RAC Report are:

- Increase overall funding at state level for DBHDD services in Georgia.
- Launch campaigns to educate legislators about public mental health services and the need for increased funding to provide these services.
- Encourage Community Service Boards to meet with local elected officials in their catchment areas to work collaboratively and creatively to use local resources to meet needs.
- Provide additional child and adolescent behavioral health services (both in schools and communities) including wrap-around services, crisis homes, expansion of 23-hour observations and/or crisis stabilization units (CSUs).
- Secure funding to add a clubhouse program.

- Increase funding to allow for expansion of Georgia Apex Program.
- Secure funding to increase the number of publicly funded CSUs.

Region 6

According to the most recent Comparison of Need to Consumers Served data from SFY2015, Region 6 had a child and adolescent population ages 9-17 of 176,965. Based on prevalence estimates there are approximately 14,157 youth with SED in Region 6. DBHDD providers in Region 6 served 1,771 youth age 9-17 in SFY15 meeting 12.5% of the overall need. Multiplying the figure by the percentage of persons having income at or below 200% of poverty, it is estimated that approximately 4,771 children with SED would need services from the public sector. In FY 16, DBHDD providers for Region 6 reached 37.1% of the estimated eligible youth needing services from the public sector.

Due to the State of Georgia's Department of Community Health (DCH) moving low income Medicaid populations and foster care, adoption assistance, and some youth in the juvenile justice system to Care Management Organizations (CMO's), the numbers served by providers through these organizations are not tracked by DBHDD. Penetrations rates in the child and adolescent population are estimated to be much higher if these numbers were included.

Region 6 ranks third in population among the six DBHDD regions and covers 9,822 square miles. Many residents live in rural areas. The region includes 31 counties. There are 22 child and adolescent providers in the region: 5 Tier 1 providers (CCPs), 13 Tier 2 providers (CMPs) and 2 Tier 3 Specialty providers. Other than core services, children and adolescents in the region also have access to care management entity, intensive family intervention services, resiliency supports clubhouse, mobile crisis, and crisis stabilization services as well as psychiatric residential treatment facility services. In FY16, 1,237 youth received core services, 174 received CSU services, 131 received IFI services and 1 received SE.

Some of the priority needs and key strategies related to child and adolescent mental health for Region 6 recommended in the 2017-2018 RAC Report are:

- Address critical staffing shortages and the need for specialty services by recruiting providers and expanding telemedicine, mobile medicine, and crisis intervention services
- Work with Community Service Boards and other providers to identify and assess critical staff shortages
- Share this information with key stakeholders
- Work with CSBs to identify and initiate creative recruitment such as partnering with colleges and nursing schools
- Recruit credentialed providers for co-occurring disorders.
- Address shortages in rural areas through telemedicine, mobile medicine and crisis intervention services.

CHILD AND ADOLESCENT MENTAL HEALTH-PLANS TO ADDRESS UNMET NEEDS

Based on information from the analysis of available data sources, Regional Advisory Council recommendations, input from the Behavioral Health Planning and Advisory Council, and the overall strategic direction of the DBHDD, the following areas will be addressed in the 2018-2019 MHBG application.

Increase Access to Mental Health Services

As indicated previously, DBHDD does not serve all youth with SED. Given the low penetration rate of services to youth with SED served by DBHDD, DBHDD recognizes that most youth are served through the Care Management Organizations under contract with DCH, the State Medicaid Authority. The Care Management Organizations have providers in their networks who are also providers under contract or letter of agreement with DBHDD. DBHDD will work with DCH and the Georgia State University Center of Excellence for Children's Behavioral Health to collect data on youth with a behavioral health diagnosis who access services through the public mental health system.

As summarized in the data and Regional Advisory Council recommendations, there is a need to expand availability of core and specialty services to children and adolescents, particularly in rural areas of the state. There are some areas where there are limited providers. In addition, there has been the need identified to provide services closer to where children live in their homes and communities to avoid more costly and intensive out of home treatment. Since transportation has been identified as a significant issue in some parts of the state, it is important that providers plan for the delivery of non-clinic-based services such as peer services, home and community- based services and Georgia Apex. In addition to school-based mental health programing, DBHDD will continue to evaluate efforts to increase the utilization of tele-behavioral health services.

DBHDD will work with other child-serving agencies and partners to increase the number of youth with SED receiving services from the public mental health system as well as increase the number of youth receiving services in their homes and communities. The FY18-19 MHBG application includes three priority areas related to this: general access to public mental health services; home and community-based mental health services; Georgia Apex school-based mental health program; and, family and youth peer support services.

Use of Evidence-based Practices and Promising Practices

The ability to keep youth in their communities and to improve their functioning is directly related to the types of services and supports made available to them and their families. DBHDD will continue to train its workforce on evidence-based and promising practices. DBHDD will also work with other child-serving agencies to promote a system of care approach to service delivery and to encourage training across child-serving agencies on EBPs. In addition, community awareness of mental health problems leads to less stigma, less involvement with criminal justice systems and increased likelihood that youth and their families will access services.

The FY18-19 MHBG application includes training as a priority area and includes 3 strategy areas: direct care staff receiving training in evidence-based and/or promising practices; individuals trained in youth mental health first aid; and child and adolescent professionals receiving training on Culturally and Linguistically Appropriate Services.

Improve Functioning of Youth with SED

DBHDD focuses on service provision that leads to improved functioning of youth with SED. The goal is to maintain youth in their homes, schools and communities and divert them from criminal justice and higher levels of care. The use of High-Fidelity Wraparound services with Care Management Entity Services provide for a coordinated approach to planning and acquiring along with a family and youth the services and supports that are needed to maintain a youth who is challenged with SED in their communities and to improve their functioning at home, in school and in their community.

In addition, mental health resiliency support clubhouses services for children and youth (ages 6-21) with behavioral health needs provide a comprehensive and unique set of services for children and families coping with the isolation, stigma, and other challenges of mental health disorders. Clubhouse Members and their families participate in clinical sessions, social outings, and career building activities, educational support, and other structured activities designed to support their needs and help them to function better at home, in school, in the community, and throughout life.

Georgia Apex, a school-based mental health services program, was developed to enhance access to the appropriate level of care; to provide early detection of child and adolescent behavioral health needs; and to develop and sustain coordination and collaboration between Georgia's community mental health providers and the school districts in their service areas. Due to its success, the program has been expanded and will continue to expand as funds become available.

Improved functioning is a goal of service delivery to maintain the youth in their home and community. The FY20-21 MHBG application includes a priority area related to improving or maintaining functioning of youth and has an indicator to track improved functioning of youth served by the CMEs utilized in High Fidelity Wraparound services; youth served by mental health clubhouses; and, youth served through Georgia Apex.

Increase Access to Deaf Mental Health Services

It is Georgia's vision that all individuals, including individuals who are deaf, deaf-blind, or hard of hearing and utilize ASL as a preferred language, have easy access to linguistically accessible and culturally competent high-quality care that leads to a life of recovery and independence. To this end, DBHDD created the Office of Deaf Services (ODS). This office is working on the following priority areas:

- Identification of Individuals with Hearing Loss.
- Identification of Communication Preferences and Needs

- Workforce Development of Georgia Behavioral Health Interpreters (GaBHIs)
- Development of Statewide Community-Based Accessible Services
- Deaf Services Provider Training Series
- Promotion of Public Information Awareness and Community Outreach

DBHDD has developed a priority area and indicator related to this population for this MHBG application. The goal is to increase access to community-based mental health services for adults with SMI and children with SED who require American Sign Language to access services.

Increase Access to Coordinated Specialty Care

Georgia has used the 10 percent set-aside funds to support its LIGHT-ETP (Listening, Inspiring, Guiding Healthy Transitions-Early Treatment Program) initiative for young people with first- episode psychosis. This initiative provides Coordinated Specialty Care (CSC) to young people between the ages of 16-30 who have been experiencing symptoms of a psychotic disorder for 24 months or less. The evidence-based practices provided by our CSC teams include medication management geared toward young people with first-episode psychosis; CBT-based psychotherapy; case management and coordination with primary care; supported education and supported employment based on the Individualized Placement and Support model; family education and support; and peer support.

Since 2014, DBHDD has been planning for development of and implementation of the CSC model. To support development, DBHDD formed a stakeholder group and hired a part-time project coordinator. Based on the stakeholder recommendations, DBHDD provided initial training on the model as well as a community awareness campaign. Also, initially DBHDD procured three providers to implement the service in 14 counties in 3 DBHDD regions. In SFY17, DBHDD secured two additional providers and expanded to an additional 20 counties in 2 more DBHDD regions. In SFY18, DBHDD secured one more provider and has expanded services to 7 additional counties. All but one DBHDD region have implemented CSC. To support the current sites and to plan for sustainability and replication, DBHDD has converted the part-time project coordinator position to a full-time position. The Project Coordinator has expertise in the provision of and training of CSC and works with each provider site to support their implementation. The Coordinator will also work internally and externally on development of financing plans for further sustainability of the CSC model.

The FY18 MHBG application includes a goals and indicator related to CSC services. DBHDD will monitor the number of individuals receiving CSC with a focus on increasing the number served as new tams are added for the provision of CSC.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Community Mental Health Services

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Access to Mental Health Services

Objective:

Increase access to mental health services.

Strategies to attain the objective:

DBHDD will work with DBHDD providers and other state agencies to support access to public mental health system services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of youth accessing services through the public mental health system.

Baseline Measurement: Initial data collected during SFY19

First-year target/outcome measurement: Due to significant budget cuts required by the state legislature, our goal is to monitor services and work to mitigate any potential negative impact on service provision during this transition year. Our year 1 goal is to maintain at least the same level of youth accessing services as in SFY19.

Second-year target/outcome measurement: Increase SFY20 number by 100 youth.

Data Source:

Medicaid and state funded claims and encounters; Georgia Collaborative Administrative Service Organization; Center of Excellence for Children's Behavioral Health, Georgia State University.

Description of Data:

Data includes number of youth accessing services through DBHDD core and specialty services.

Data issues/caveats that affect outcome measures::

Data will be compiled from different sources.

Indicator #: 2

Indicator: Percentage of youth receiving at least one home- and community-based mental health service.

Baseline Measurement: Initial data collected during SFY19

First-year target/outcome measurement: Due to significant budget cuts required by the state legislature, our goal is to monitor services and work to mitigate any potential negative impact on service provision during this transition year. Our year 1 goal is to maintain at least the same level of youth accessing services as in SFY19.

Second-year target/outcome measurement: Increase by 1% over data reported in SYF20.

Data Source:

Medicaid and state funded claims and encounters; Georgia Collaborative Administrative Service Organization.

Description of Data:

Data includes number of youth accessing services through DBHDD providers, such as Community Support Individual and Intensive Family Intervention.

Data issues/caveats that affect outcome measures::

School-based mental health services will be reported separately.

Indicator #: 3

Indicator: Number of youth accessing services through the Georgia Apex school-based mental health program.

Baseline Measurement: Initial data collected during SFY19

First-year target/outcome measurement: Increase by 250 youth over baseline data.

Second-year target/outcome measurement: Increase baseline number by 250 youth over data reported in SYF20.

Data Source:

Data reported to Center of Excellence for Children's Behavioral Health, Georgia State University.

Description of Data:

Data includes number of youth accessing services through DBHDD Tier 1 and Tier 2 providers embedded in schools.

Data issues/caveats that affect outcome measures::

The data relies on providers self-reporting.

Indicator #: 4

Indicator: Number of youth and families receiving peer services.

Baseline Measurement: Initial data collected during SFY19

First-year target/outcome measurement: Due to significant budget cuts required by the state legislature, our goal is to monitor services and work to mitigate any potential negative impact on service provision during this transition year. Our year 1 goal is to maintain at least the same level of youth and families receiving peer services as in SFY19.

Second-year target/outcome measurement: Increase by 1% over data reported in SFY19.

Data Source:

Medicaid claims and encounters; Georgia Collaborative Administrative Service Organization; Georgia Parent Support Network program data

Description of Data:

Data includes number of youth and parents receiving support through the DBHDD provider network from a certified parent or youth peer.

Data issues/caveats that affect outcome measures::

This will be a new measure tracked through the Georgia Collaborative Administrative Service Organization.

Priority #: 2

Priority Area: Training

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Train DBHDD providers on evidence-based and/or promising practices

Objective:

DBHDD providers are trained on and implementing evidence-based practices and/or promising practices (EBPs/PPs)

Strategies to attain the objective:

DBHDD will train enrolled providers in evidence-based and/or promising practices. Use of EBPs/PPs are indicated in the DBHDD Provider Manual.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of direct care staff receiving training in evidence-based and/or promising practices.

Baseline Measurement: Initial data collected during SFY19

First-year target/outcome measurement: Increase by 5% over data reported in SFY19.

Second-year target/outcome measurement: Increase by 2% over data reported in SFY20.

Data Source:

DBHDD Office of Learning and vendor reports.

Description of Data:

Data collected from registration and attendance lists.

Data issues/caveats that affect outcome measures::

Data will be compiled from different sources.

Indicator #: 2

Indicator: Number of individuals trained in youth mental health first aid.

Baseline Measurement: Initial data collected prior to and during SFY19

First-year target/outcome measurement: Increase baseline number by 50 child serving professionals over SFY19 data.

Second-year target/outcome measurement: Increase number by 50 child serving professionals over SFY20 data.

Data Source:

YMHFA vendor reports.

Description of Data:

Data collected from attendance lists. YMHFA is primarily designed for adults (e.g., family members, caregivers, school staff, etc.) who regularly engage with young people 12-25. However, YMHFA is also appropriate as a peer support program for older adolescents.

Data issues/caveats that affect outcome measures::

The DBHDD Office of Children, Young Adults & Families contracts for YMHFA to build capacity for trained individuals in the state.

Indicator #: 3

Indicator: Number of CYF professionals participating in a Culturally and Linguistically Appropriate Services (CLAS) training.

Baseline Measurement: Initial data collected during SFY19

First-year target/outcome measurement: Increase number by 35 child-serving professionals over SFY19.

Second-year target/outcome measurement: Increase number by 75 child-serving professionals over SFY20.

Data Source:

DBHDD Office of Learning and vendor reports.

Description of Data:

Data collected from registration lists.

Data issues/caveats that affect outcome measures::

This will be a new measure tracked by DBHDD.

Priority #: 3

Priority Area: Improved Functioning

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Children and youth receiving services will improve functioning.

Objective:

To increase functioning of children and adolescents who receive community mental health services.

Strategies to attain the objective:

Providers will work with youth and their families with the goal of improving youth functioning in homes, schools, and communities.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of youth receiving High Fidelity Wraparound services from Care Management Entity (CME) who increase functioning.

Baseline Measurement: Initial data collected during SFY19

First-year target/outcome measurement: Increase by 1% over data reported in SFY19

Second-year target/outcome measurement: Increase by 1% over data reported in SFY20.

Data Source:

Center of Excellence for Children's Behavioral Health, Georgia State University; CME annual evaluation.

Description of Data:

CMEs will measure functioning using the Child and Adolescent Needs and Strengths (CANS) tool.

Data issues/caveats that affect outcome measures::

DBHDD is evaluating the utility of switching to a new electronic health record system.

Indicator #: 2

Indicator: Percentage of youth mental health clubhouse members who increase functioning.

Baseline Measurement: Initial data collected during SFY19

First-year target/outcome measurement: Due to significant budget cuts required by the state legislature, our goal is to monitor services and work to mitigate any potential negative impact on service provision during this transition year. Our year 1 goal is to maintain at least the same percentage of youth mental health clubhouse members who increase functioning as in SFY19.

Second-year target/outcome measurement: Increase by 1% over data reported in SFY20.

Data Source:

Center of Excellence for Children's Behavioral Health, Georgia State University; mental health clubhouse annual evaluation.

Description of Data:

DBHDD mental health clubhouse providers will measure functioning using the Child and Adolescent Needs and Strengths (CANS) tool.

Data issues/caveats that affect outcome measures::

This will be a new measure tracked by DBHDD.

Indicator #: 3

Indicator: Percentage of school-based mental health program members who increase functioning.

Baseline Measurement: Initial data collected prior to and during SFY19

First-year target/outcome measurement: Due to significant budget cuts required by the state legislature, our goal is to monitor services and work to mitigate any potential negative impact on service provision during this transitional year. Our year 1 goal is to maintain at least the same percentage of school-based mental health program members who increase functioning as in SFY19.

Second-year target/outcome measurement: Increase by 1% over data reported in SFY20

Data Source:

Center of Excellence for Children's Behavioral Health, Georgia State University; Georgia Apex Program annual evaluation.

Description of Data:

DBHDD Apex providers will measure functioning using the Child and Adolescent Needs and Strengths (CANS) tool.

Data issues/caveats that affect outcome measures::

This will be a new measure tracked by DBHDD.

Priority #: 4

Priority Area: Access to Coordinated Specialty Care

Priority Type:

Population(s): ESMI

Goal of the priority area:

Youth and young adults ages 16-30 with First-Episode Psychosis will receive Coordinated Specialty Care (CSC) services.

Objective:

To continue to increase the number of youth and young adults receiving CSC services.

Strategies to attain the objective:

DBHDD will continue to provide technical assistance to CSC providers to ensure that their community outreach and education efforts result in referrals of eligible youth and young adults into CSC programs.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of youth and young adults with FEP receiving CSC services.

Baseline Measurement: SFY16 will serve as the baseline year. DBHDD expected that providers in the three pilot sites would enroll a minimum of 60 individuals during the baseline year. The three pilot sites enrolled 87 individuals in SFY16. DBHDD's goal for SFY17 was a 10% increase in the number of individuals served in SFY16. In SFY17, 105 individuals were served in CSC programs. DBHDD's goal for SFY18 was a 5% increase in the number of individuals served in SFY17. In

SFY18, 196 individuals were served in CSC programs. DBHDD's goal for SFY19 was a 5% increase in the number of individuals served in SFY18. In SFY19, 219 individuals were served in CSC programs.

First-year target/outcome measurement: DBHDD will increase the number of individuals with first-episode psychosis receiving CSC services by 5% over the number served in SFY2019.

Second-year target/outcome measurement: DBHDD will increase the number of individuals with first-episode psychosis receiving CSC services by 5% over the number served in SFY2020.

Data Source:

Monthly reports completed by providers.

Description of Data:

Number of individuals with FEP enrolled and retained in CSC services

Data issues/caveats that affect outcome measures::

None.

Priority #: 5

Priority Area: Deaf Mental Health Services

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Access to community-based non-crisis mental health therapy (individual, family and group)

Objective:

Increase access to non-crisis therapy for adults with SMI and children with SED who require American Sign Language (ASL) or visual gestural language to access services and are state (uninsured) or Medicaid (SSI) funded.

Strategies to attain the objective:

DBHDD will work with DBHDD Designated Provider(s) and other state agencies to support access to public mental health

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of individuals who: are identified as deaf; receive state or Medicaid funds; and, are authorized for community-based non-crisis mental health therapy that receive a Communication Assessment Report.

Baseline Measurement: Number of individuals who: are identified as deaf; receive state or Medicaid funds; and, are authorized for community-based non-crisis mental health therapy that receive a Communication Assessment Report in SFY19.

First-year target/outcome measurement: 5% increase over data reported in SFY19.

Second-year target/outcome measurement: 7% increase over data reported in SFY20.

Data Source:

Designated Provider Data Reports, Administrative Services Organization (ASO) and Deaf Services Data Management System (DSMS)

Description of Data:

DP Data Reports – Monthly service reports of individuals who are being served through the ASL program.

ASO – Monthly database report of individuals identified as deaf (adults and children), receive state (uninsured) or Medicaid (non-MCO) funds, and are authorized for community-based non-crisis mental health therapy (individual, group, and family) services.

DSMS – Monthly database report of individuals identified as deaf (adults and children), receive state (uninsured) or Medicaid (non-MCO) funds, and are authorized for community-based non-crisis mental health therapy (individual, group, and family) services that have a Communication Assessment Report.

The indicator percentage will be based on the number of individuals from the DSMS report that are present on the ASO report as compared between the Designated Provider Reports of those receiving services in the first and second years.

Data issues/caveats that affect outcome measures::

None

Priority #: 6

Priority Area: Permanent Supported Housing

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Increase access to permanent supported housing for adults enrolled in AMH services.

Objective:

To support access to permanent supported housing for eligible individuals.

Strategies to attain the objective:

DBHDD will increase access to HUD Section 811 program, and DCA Housing Choice Vouchers for eligible adults with SMI.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of adults with SMI receiving State assisted permanent supported housing.

Baseline Measurement: Initial data collected during SFY19

First-year target/outcome measurement: Due to significant budget cuts required by the state legislature, our goal is to monitor services and work to mitigate any potential negative impact on service provision during this transition year. Our year 1 goal is to maintain at least the same number of adults with SMI receiving State assisted permanent supported housing. as in SFY19.

Second-year target/outcome measurement: Increase number served by 3% over the total served in SFY20

Data Source:

Office of Adult Mental Health data base, Department of Community Affairs data base/Statewide Information System

Description of Data:

Compiled monthly reports of individuals housed via the GHV, HCV OR 811 rental assistance programs.

Data issues/caveats that affect outcome measures::

None

Priority #: 7

Priority Area: Provider training

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Provision of diverse training to community adult mental health providers

Objective:

Increase access to training focused on supporting the behavioral health of diverse populations of adults with SMI

Strategies to attain the objective:

DBHDD will provide high quality training to community adult mental health providers throughout the state that will increase skills in supporting the behavioral health needs of diverse populations.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Provision of training on each of the following topics: Trauma-informed Care; Recovery focused service delivery; Cultural and linguistic competency; behavioral health needs of veterans; behavioral health needs of those with criminal history; Mental Health First Aid; and, behavioral health needs of LGBT individuals

Baseline Measurement: Initial data collected during SFY2019

First-year target/outcome measurement: Due to significant budget cuts required by the state legislature, our goal is to monitor training expenditures and work to mitigate any potential negative impact on training delivery during this transition year. Our year 1 goal is to maintain at least the same number of providers who are trained in the above topic areas .as in SFY19.

Second-year target/outcome measurement: Increase number of providers trained by 5% above SFY20 totals.

Data Source:

DBHDD Office of Adult Mental Health data.

Description of Data:

Training plan reflecting dates and topics.

Data issues/caveats that affect outcome measures::

None

Priority #: 8

Priority Area: Supported Employment

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Increase access to competitive employment for adults enrolled in AMH services.

Objective:

Increase number of adults with SMI to obtain and maintain competitive employment.

Strategies to attain the objective:

DBHDD contracts for the provision of Supported Employment services statewide. Collect data on number of individuals working part or full time in competitive employment settings for adults with SMI receiving State funded Supported Employment services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of adults with SMI who are competitively employed part-time or full-time while enrolled in adult mental health Supported Employment services.

Baseline Measurement: Initial data collected prior to and during SFY19

First-year target/outcome measurement: Due to significant budget cuts required by the state legislature, our goal is to monitor

services and work to mitigate any potential negative impact on service provision during this transition year. Our year 1 goal is to maintain at least the same percentage of adults with SMI who are competitively employed part-time or full-time while enrolled in adult mental health Supported Employment services. as in SFY19.

Second-year target/outcome measurement: Increase percentage of SE enrolled individuals who are competitively employed by 5% above SFY20 number.

Data Source:

DBHDD Office of Adult Mental Health data.

Description of Data:

Compiled monthly reports of individuals enrolled in SE, and % of individuals competitively employed.

Data issues/caveats that affect outcome measures::

None

Priority #: 9

Priority Area: Access to Services-Older Adults

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Improve providers ability to support the behavioral health needs of older adults

Objective:

Increase access to community mental health services by adults with SMI aged 65 and older.

Strategies to attain the objective:

Offer training opportunities that will enhance providers ability to deliver behavioral health services to adults age 65+

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of adults with SMI age 65+ that receive community mental health services.

Baseline Measurement: Initial data collected during SFY19

First-year target/outcome measurement: Due to significant budget cuts required by the state legislature, our goal is to monitor services and work to mitigate any potential negative impact on service provision during this transition year. Our year 1 goal is to maintain at least the same percentage of adults with SMI age 65+ that receive community mental health services as in SFY19.

Second-year target/outcome measurement: Increase by 2% the number of 65+ individuals who received community based adult mental health services in SFY20

Data Source:

DBHDD Office of Adult Mental Health data.

Description of Data:

Authorizations submitted for AMH services for persons 65+

Data issues/caveats that affect outcome measures::

None

Indicator #: 2

Indicator: Provision of cross training for behavioral health providers on awareness and issues related to the delivery of mental health services to older adults with SMI.

Baseline Measurement: Initial data collected during SFY19

First-year target/outcome measurement: Due to significant budget cuts required by the state legislature, our goal is to monitor training expenditures and work to mitigate any potential negative impact on training delivery during this transition year. Our year 1 goal is to maintain at least the same number of providers who receive cross training for behavioral health providers on awareness and issues related to the delivery of mental health services to older adults with SMI as in SFY19.

Second-year target/outcome measurement: Increase number of providers trained by 10% over SFY20.

Data Source:

DBHDD Office of Adult Mental Health data.

Description of Data:

Training plan reflecting dates and topics.

Data issues/caveats that affect outcome measures::

None

Priority #: 10

Priority Area: Access to Services- Criminal Justice

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Access to behavioral health services for returning citizens/criminal justice involved individuals with behavioral health needs.

Objective:

To improve access to community behavioral health service for persons with behavioral health needs transitioning from a criminal justice facility back into the community.

Strategies to attain the objective:

Increase efforts to support access to behavioral health services for criminal justice involved individuals with behavioral health needs.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of adults with SMI referred from jail, prison, and Day Reporting Centers to community mental health services.

Baseline Measurement: Initial data collected prior to and during SFY19

First-year target/outcome measurement: Due to significant budget cuts required by the state legislature, our goal is to monitor services and work to mitigate any potential negative impact on service provision during this transition year. Our year 1 goal is to maintain at least the same number of adults with SMI referred from jail, prison, and Day Reporting Centers to community mental health services as in SFY19.

Second-year target/outcome measurement: Increase by 3% the number of adults with SMI referred from jail, prison or a Day Reporting Center into community mental health services above the SFY20 total.

Data Source:

Office of Adult Mental Health data, DBHDD Administrative Services Organization.

Description of Data:

Authorizations submitted for AMH services for persons from jail, prison, and Day Reporting Center

Data issues/caveats that affect outcome measures::

None

Indicator #: 2

Indicator: Number of adults with SMI receiving forensic peer support.

Baseline Measurement: Initial data collected prior to and during SFY19

First-year target/outcome measurement: Due to significant budget cuts required by the state legislature, our goal is to monitor services and work to mitigate any potential negative impact on service provision during this transition year. Our year 1 goal is to maintain at least the same number of adults with SMI receiving forensic peer support as in SFY19.

Second-year target/outcome measurement: Increase by 5% over SFY20 data.

Data Source:

Office of Adult Mental Health data,

Description of Data:

Compiled monthly report data from forensic peer specialists

Data issues/caveats that affect outcome measures::

None

Priority #: 11

Priority Area: Access to Community Mental Health Services for Homeless Individuals with SMI

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Increase number of homeless individuals with SMI accessing community adult mental health services.

Objective:

To improve awareness of and access to community behavioral health services for homeless individuals with SMI

Strategies to attain the objective:

To build upon current use of PATH services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of adults with SMI receiving PATH services for homeless individuals with behavioral health needs

Baseline Measurement: Initial data collected prior to and during SFY19

First-year target/outcome measurement: Due to significant budget cuts (required by the state legislature) in areas that frequently coordinate with delivery of PATH services, our goal is to monitor services and work to mitigate any potential negative impact on service provision during this transition year. Our year 1 goal is to maintain at least the same number of adults with SMI receiving PATH services for homeless individuals with behavioral health needs as in SFY19.

Second-year target/outcome measurement: Increase number of persons served by PATH by 3% above the SFY20 total.

Data Source:

Statewide HMIS System; ASO data

Description of Data:

Comparison of authorizations submitted for AMH services, past – current fiscal years, monthly report census data for PATH

Data issues/caveats that affect outcome measures::

None

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Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2020/2021.

Planning Period Start Date: 7/1/2019 Planning Period End Date: 6/30/2021

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention and Treatment							
a. Pregnant Women and Women with Dependent Children							
b. All Other							
2. Primary Prevention							
a. Substance Abuse Primary Prevention							
b. Mental Health Primary Prevention *		$0	$0	$30,661,016	$1,764,562	$0	$0
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG) **		$2,223,070	$0	$0	$0	$0	$0
4. Tuberculosis Services							
5. Early Intervention Services for HIV							
6. State Hospital			$2,828,942	$0	$103,847,917	$0	$820,122
7. Other 24 Hour Care		$0	$0	$0	$304,789,943	$0	$0
8. Ambulatory/Community Non-24 Hour Care		$18,671,218	$34,365,827	$3,089,183	$538,394,533	$0	$1,547,321
9. Administration (Excluding Program and Provider Level) ***		$1,099,524	$0	$0	$32,546,688	$0	$0
10. Total	**$0**	**$21,993,812**	**$37,194,769**	**$33,750,199**	**$981,343,643**	**$0**	**$2,367,443**

* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED

** Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside

*** Per statute, Administrative expenditures cannot exceed 5% of the fiscal year award.

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Footnotes:

Planning Tables

Table 6 Non-Direct Services/System Development

MHBG Planning Period Start Date: 07/01/2019 MHBG Planning Period End Date: 06/30/2021

Activity	FFY 2020 Block Grant	FFY 2021 Block Grant
1. Information Systems	$0	$0
2. Infrastructure Support	$1,253,036	$722,496
3. Partnerships, community outreach, and needs assessment	$0	$0
4. Planning Council Activities (MHBG required, SABG optional)	$127,272	$127,272
5. Quality Assurance and Improvement	$0	$0
6. Research and Evaluation	$0	$0
7. Training and Education	$818,740	$739,884
8. Total	**$2,199,048**	**$1,589,652**

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Footnotes:

Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[22] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[23] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[24]

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[25] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[26] For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.[27]
Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[28]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[29] The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.
Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.[30] Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[31] and ACOs[32] may be important strategies used by SMHAs and SSAs to foster integrated care.
Training and assisting M/SUD providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.
SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.[33] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[34]
One key population of concern is persons who are dually eligible for Medicare and Medicaid.[35] Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[36] SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment.[37] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[38] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD conditions and work with

partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.
SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[39] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states' Medicaid authority in ensuring parity within Medicaid programs.
SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.
Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[40]
SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.[41] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

[22] BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Med Care. 2011 Jun; 49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, Bulletin of the World Health Organization, 2013; 91:102-123 http://www.who.int/bulletin/volumes/91/2/12-108282.pdf MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, World Psychiatry. Feb 2011; 10(1): 52-77

[23] Research Review of Health Promotion Programs for People with SMI, 2012, http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper About SAMHSA's Wellness Efforts https://www.samhsa.gov/wellness-initiative JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, JAMA; 2007; 298: 1794-1796; Million Heart https://www.samhsa.gov/health-care-health-systems-integration Schizophrenia as a health disparity, http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml

[24] Comorbidity: Addiction and other mental illnesses http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, JAMA Psychiatry. 2014; 71 (3):248-254. doi:10.1001/jamapsychiatry.2013.3726 http://www.samhsa.gov/co-occurring/

[25] Social Determinants of Health, Healthy People 2020 http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39 https://www.cdc.gov/nchhstp/socialdeterminants/index.html

[26] http://www.samhsa.gov/health-disparities/strategic-initiatives

[27] http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/

[28] Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011 https://www.integration.samhsa.gov/integrated-care-models/FG-Integrating_12.22.pdf; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011, https://www.ahrq.gov/downloads/pub/evidence/pdf/mhsapc/mhsapc.pdf Abrams, Michael T. (2012, August 30). Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and Challenges. Baltimore, MD: The Hilltop Institute, UMBC. http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf American Psychiatric Association, http://www.psych.org/practice/professional-interests/integrated-care Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series (2006), Institute of Medicine, National Affordable Care Academy of Sciences, http://books.nap.edu/openbook.php?record_id=11470&page=210 State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011 http://nasadad.org/nasadad-reports

[29] Health Care Integration, http://samhsa.gov/health-reform/health-care-integration SAMHSA-HRSA Center for Integrated Health Solutions, (http://www.integration.samhsa.gov/

[30] Health Information Technology (HIT), http://www.integration.samhsa.gov/operations-administration/hit Characteristics of State Mental Health Agency Data Systems, Telebehavioral Health and Technical Assistance Series https://www.integration.samhsa.gov/operations-administration/telebehavioral-health State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association http://www.americantelemed.org/home National Telehealth Policy Resource Center, http://telehealthpolicy.us/medicaid

[31] Health Homes, http://www.integration.samhsa.gov/integrated-care-models/health-homes

[32] New financing models, https://www.integration.samhsa.gov/financing

[33] Waivers, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS Informational Bulletin, Dec. 2012, http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf

[34] What are my preventive care benefits? https://www.healthcare.gov/what-are-my-preventive-care-benefits/ Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html

[35] Medicare-Medicaid Enrollee State Profiles http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html About the Compact of Free Association, http://uscompact.org/about/cofa.php

[36] Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, http://www.cbo.gov/publication/44308

[37] BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs. 2014; 33(4): 700-707

[38] TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry. 2014; 71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. JAMA Psychiatry. 2013; 70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. Annals of Emergency Medicine. 2011; 58(2): 218

[39] Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf Creating jobs by addressing primary care workforce needs, https://obamawhitehouse.archives.gov/the-press-office/2012/04/11/fact-sheet-creating-health-care-jobs-addressing-primary-care-workforce-n

[40] About the National Quality Strategy http://www.ahrq.gov/workingforquality/about.htm National Behavioral Health Quality Framework, Draft, August 2013, http://samhsa.gov/data/NBHQF

[41] Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2013 http://www.cms.gov/cciio/resources/letters/index.html Affordable Care Act, Indian Health Service http://www.ihs.gov/ACA/

Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

   Georgia has implemented a service called Peer Support Whole Health and Wellness which allows Certified Peer Specialists who are trained in whole health principles to support individuals in achieving health goals. These CPSs are trained in the Whole Health Action Management curriculum. The state continues to grow this workforce offering this additional certification opportunity to at least 60 CPSs/year. The state is also implementing a new modality of delivering this service, complementing the existing 1:1 service delivery model with a new group model (effective Fall 2017).

   Additionally, several services in the benefit which DBHDD provides allow health access and promotion. Nursing services allow basic health screening including BMI measurement, weight monitoring, blood pressure screening and vitals monitoring. Case management services promote facilitating access to health interventions and coordination with those healthcare practitioners.

   The DBHDD has also worked with the state's Medicaid authority to clarify the billing allowance for same-day service provision between the DBHDD provider network and Federally Qualified Health Centers (FQHCs) (effective January 2019) and to release guidance to providers on how to access smoking cessation supports through a Medicaid-enrolled primary care physician.

2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

   Since the early 2000s, the DBHDD has promoted MH and SUD integration at the person-served point of access. The basic core services provided by our agency share integrated policy, authorization procedures, and payment strategies. For instance, our Individual Counseling definition is for either individuals with a mental illness, substance use disorder, or both. When an authorization is reviewed, it considers one or both of the conditions (without mandate to address one condition or the other).Rates of reimbursement are also identical..

   The state has also recently introduced Parent and Youth Peer Support to the state benefit plan. Certified Peer Specialist- Parents (CPS-Ps) and Certified Peer Specialists-Youth (CPS-Ys) receive a co-occurring-competent curriculum and training to be prepared to serve the needs of all individuals regardless of whether there is a mental health condition, substance use disorder, or both.

   In October 2017, DBHDD and the State Medicaid authority added Behavioral Health Clinical Consultation to the Medicaid State Plan for Georgia. This service enables a physician/extender with the enrolled DBHDD agency provides to provide or receive

specialty expertise opinion and/or treatment advice to/from another treating physician/extender regarding an individual who is enrolled receiving DBHDD services/supports. The service promotes:

- Sound, collaborative clinical/medical opinions from other experts related to the behavioral health condition; and/or
- Assistance for the behavioral health/medical provider with diagnosing; and/or
- Consultation about alternatives to medication, medication combined with psychosocial treatments and potential results of medication usage; and/or
- Identification and planning for additional services; and/or
- Coordination or informed revision to a treatment and/or recovery plan; and/or
- Understanding of the complexities of co-occurring medical conditions on the individual's behavioral health recovery plan (e.g. kidney failure, diabetes, high blood pressure, etc.); and/or
- Partnered review of the individual's progress for the purposes of collaborative treatment outcomes.

3. **a)** Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs? ☐ Yes ☐ No

   b) and Medicaid? ☐ Yes ☐ No

4. Who is responsible for monitoring access to M/SUD services by the QHP?

   DBHDD as SSA/SMHA

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? ☐ Yes ☐ No

6. Do the M/SUD providers screen and refer for:

   a) Prevention and wellness education ☐ Yes ☐ No

   b) Health risks such as

   ii) heart disease ☐ Yes ☐ No

   iii) hypertension ☐ Yes ☐ No

   iv) high cholesterol ☐ Yes ☐ No

   v) diabetes ☐ Yes ☐ No

   c) Recovery supports ☐ Yes ☐ No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? ☐ Yes ☐ No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? ☐ Yes ☐ No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

   There has been turnover in leadership at the Office of the Insurance Commissioner.
   Issues with capacity within state insurance office to complete parity review and follow up

10. Does the state have any activities related to this section that you would like to highlight?

    The state has a collaborative review committee which includes the Office of the Insurance Commissioner, SMHA, and SMA to consider parity for Medicaid Managed Care and private insurance. That team has presented together at the SMHA's System of Care conference which includes payers, families, youth and providers.

    Please indicate areas of technical assistance needed related to this section

    None at this time.

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Footnotes:

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[42], **Healthy People, 2020**[43], **National Stakeholder Strategy for Achieving Health Equity**[44], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for **Culturally and Linguistically Appropriate Services in Health and Health Care** (CLAS)[45].

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[46]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[47]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[48]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

[42] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[43] http://www.healthypeople.gov/2020/default.aspx

[44] https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf

[45] http://www.ThinkCulturalHealth.hhs.gov

[46] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[47] https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status

[48] https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?
   - a) Race ☐ Yes ☐ No
   - b) Ethnicity ☐ Yes ☐ No
   - c) Gender ☐ Yes ☐ No
   - d) Sexual orientation ☐ Yes ☐ No
   - e) Gender identity ☐ Yes ☐ No
   - f) Age ☐ Yes ☐ No
2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? ☐ Yes ☐ No
3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? ☐ Yes ☐ No
4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? ☐ Yes ☐ No
5. If yes, does this plan include the Culturally and Linguistically Appropriate Services(CLAS) Standards? ☐ Yes ☐ No
6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? ☐ Yes ☐ No
7. Does the state have any activities related to this section that you would like to highlight?

   Although DBHDD does not have a formalized workforce training plan, DBHDD annually offers cultural and linguistic competence training at its Annual Provider Behavioral Health Symposium and has included an overview of the CLAS Standards during these sessions.

   The annual Georgia School of Addiction Studies (GSAS) offers a unique opportunity for professional development, information exchange, and networking. It is designed to address the need for knowledge and skill development through advanced training. The purpose of the GSAS is to: 1) foster and maintain the integrity of substance abuse related services by assisting in providing continuing training and education programs for more than 500 human service providers each year whose duties include prevention, intervention, treatment, law enforcement, child welfare, victim's services, law enforcement, court system, education, and rehabilitation or related social services; 2) to promote a broader understanding of, response to, and acceptance of, the process of addiction and its impact in areas of health, family, community, crime and the workplace; and 3) to encourage the exchange of professional knowledge through educational conferences and other programs of continuing education.

   Six DBHDD Office of Addictive Disease staff and two members of the Office of Behavioral Health Prevention staff serve on the Georgia School of Addiction Studies Board and help plan the conference program agenda. The five day annual conference includes a treatment track on Cultural Competency. The 13th Annual Conference, held August 26-29, 2019 includes the following training workshops: Exploring Innovative Evaluation Approaches to Better Understand the Changing Faces of Rural Communities; Implementing Cultural Competence in a Trauma Informed Setting for Emerging Adults with Co-Occurring Disorders; Understanding Military Re-Entry Needs Back into the Community; Cultural Competency for the Prevention Professional– Part 1 &2; Why are Bisexual and Transgender Populations Overlooked Within the LGBTQ Spectrum?; Addiction In The Church: Bridging the Gap Between Christianity and Recovery; and Retaining and Treating Women with Substance Use Disorders: Being Gender Responsive and Culturally Sensitive.

   A past workgroup within DBHDD developed a draft CLC Action Plan outlining steps to be taken by the Department to address items 2-6, however, that plan has not been approved as of this time. In August 2018 DBHDD created the new Office of Federal Grant Programs and Cultural and Linguistic Competency, inorder to prioritize CLC goals and objectives. The Director of this Office will lead the Department in revising the existing CLC Action Plan and implementing policy and practice changes for the state in this area.

   Please indicate areas of technical assistance needed related to this section

   We are open to any technical assistance related to addressing items 2-6.

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Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ÷ Cost, (**V = Q ÷ C**

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state M/SUD authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General,[49] The New Freedom Commission on Mental Health,[50] the IOM,[51] NQF,and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).[52]. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[53] SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[54] are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[55] was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

[49] United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[50] The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

[51] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

[52] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[53] http://psychiatryonline.org/

[54] http://store.samhsa.gov

[55] http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? ☐ Yes No

2. Which value based purchasing strategies do you use in your state (check all that apply):

   a) ☐ Leadership support, including investment of human and financial resources.

   b) ☐ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.

   c) ☐ Use of financial and non-financial incentives for providers or consumers.

   d) Provider involvement in planning value-based purchasing.

   e) Use of accurate and reliable measures of quality in payment arrangements.

   f) Quality measures focus on consumer outcomes rather than care processes.

   g) Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).

   h) The state has an evaluation plan to assess the impact of its purchasing decisions.

3. Does the state have any activities related to this section that you would like to highlight?

   The state has set forth a set of performance expectations for its provider network which include measures for access, provider capacity, consumer choice, provider efficiency, and adherence to service policy, to name a few. These measures are monitored and reported annually. DBHDD is in the developmental stages of creating dashboard report cards to promote use of the findings for quality improvement.

   As related to evidence-based fidelity, the DBHDD continues to utilize the Dartmouth models of fidelity for its Assertive Community Treatment program and Supported Employment service delivery.

   Please indicate areas of technical assistance needed related to this section.

   None

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2. C. We are in the testing phase of this with a small pilot program related to assisting individuals that are frequent users of the crisis system.

Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode **(RAISE)** initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)? ☐ Yes ☐ No

2. Has the state implemented any evidence-based practices (EBPs) for those with ESMI? ☐ Yes ☐ No

   If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

   Georgia has used the 10 percent set-aside funds to support its LIGHT-ETP (Listening, Inspiring, Guiding Healthy Transitions -Early Treatment Program) initiative for young people with first-episode psychosis. This initiative provides Coordinated Specialty Care (CSC) to young people between the ages of 16-30 who have been experiencing symptoms of a psychotic disorder for 24 months or less. The evidence-based practices provided by our Coordinated Specialty Care teams include medication management geared toward young people with first-episode psychosis; CBT-based psychotherapy; case management and coordination with primary care; supported education and supported employment based on the Individualized Placement and Support model; family education and support; and peer support.

   Currently Georgia funds eight (8) CSC teams operated through five (5) Community Service Boards, the publicly-funded system of services for mental health, substance abuse, and intellectual disability; and one (1) hospital.

3. How does the state promote the use of evidence-based practices for individuals with ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

Our providers offering Coordinated Specialty Care programs conduct extensive community outreach and education to ensure that community stakeholders including area hospitals, first responders, crisis stabilization centers, behavioral health providers, primary care providers, child-serving agencies, colleges, high schools, technical schools, jail diversion programs, homeless shelters, advocacy organizations, and other entities are aware of the signs and symptoms of early psychosis, are familiar with Coordinated Specialty Care, and know how to refer individuals to CSC programs. To supplement the providers' outreach efforts, DBHDD developed a public awareness campaign on first-episode psychosis and CSC targeted to the communities where the CSC programs are located. The campaign included print and radio ads, billboards, and social media posts. In addition, DBHDD has promoted its first-episode initiative and the importance of comprehensive, individualized treatment for young people in the early stages of severe mental illness through presentations at statewide behavioral health committee meetings, conferences, and training events.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with ESMI? ☐ Yes No

5. Does the state collect data specifically related to ESMI? ☐ Yes No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI? ☐ Yes No

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

In 2016 and 2017, the state continued to fund Coordinated Specialty Care programs established in April 2015 at Advantage Behavioral Health Systems, covering 10 counties in the Athens, GA area; and at View Point Health in Atlanta, which expanded to operate two teams serving a five-county urban/suburban area. DBHDD also began funding three additional CSC programs: Albany Aspire, covering rural communities in and around the Albany, GA region; River Edge Behavioral Health, in Macon; and McIntosh Trail Community Service Board, in the south Metro Atlanta area. The target population, initially individuals between the ages of 16 -25 who have been experiencing symptoms of psychosis for no longer than 18 months, was broadened to include individuals between 16-30 who have been experiencing symptoms for no longer than 24 months. The teams have similar staffing patterns (Team Lead/Therapist, Case Manager, Supported Education/Employment Specialist, Peer Support Specialist, Family Peer Specialist, Nurse, Prescriber) and have maximum caseloads of 30 individuals at a point in time.

In 2018, DBHDD funded another Coordinated Specialty Care program at New Horizons Behavioral Health in Columbus, GA. This team began serving individuals in October 2018. In June of 2019, the eighth CSC team began operating at Grady Health System in Atlanta, GA.

DBHDD has been providing ongoing training and technical assistance to all CSC programs and holds quarterly Learning Collaborative meetings for all CSC program staff and DBHDD field office representatives. The Learning Collaboratives are opportunities for CSC programs to exchange knowledge and resources and to address implementation and sustainability challenges. As the state's newer CSC programs began start-up activities, the initial teams were instrumental in providing guidance and sharing best practices.

CSC teams have presented on their work at national and statewide conferences and training events, including the annual Behavioral Health Symposium and System of Care Academy. Two of Georgia's teams are participating in the SAMHSA/NIMH National Evaluation of the Mental Health Block Grant Ten Percent Early Intervention Study examining the implementation of CSC programs around the country.

DBHDD continues to partner with Georgia State University's Center of Excellence on data collection, analysis, and fidelity and outcomes monitoring for the CSC programs and participates in national technical assistance opportunities focused on program improvement and sustainability.

8. Please describe the planned activities for FFY 2020 and FFY 2021 for your state's ESMI programs including psychosis?

DBHDD plans to (1) continue supporting our eight (8) CSC programs; (2) provide ongoing training and technical assistance to all CSC programs; (3) continue holding quarterly Learning Collaborative meetings; (4) continue providing information and training on first-episode psychosis and best practices to our provider network and community partners through existing forums; and (5) collaborate with Georgia State University's Center of Excellence on fidelity and outcomes reviews, surveys of program participants' and families' experiences in CSC programs; and satisfaction with services.

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

DBHDD and Georgia State University's Center of Excellence (COE) have developed fidelity and outcomes monitoring reports for the CSC programs. The providers complete these reports on a monthly basis, and the COE compiles this data into quarterly reports which are reviewed with providers individually and during the quarterly Learning Collaborative meetings.

Information obtained from providers includes baseline data on program participants at enrollment in the CSC program (age, gender, race/ethnicity, insurance, diagnosis, education, employment, family involvement, living situation, hospitalizations, suicidality, substance use detox/rehab admissions, legal system involvement) as well as the following data elements:

- Number of referrals received
- Referral sources
- Number of eligible and ineligible individuals referred, and reasons for ineligibility
- Length of time between referral and enrollment of eligible individuals

- Length of time between enrollment and appointment with team prescriber
- Program census
- Discharges, reasons for discharge, and services to which discharged participants were linked
- Service utilization rates
- Outcomes, including symptom reduction, hospitalizations, suicide attempts, legal system involvement, work/school participation
- Team activities, including weekly team meetings held and participating staff
- Number and type of community outreach/education activities and events
- Number and type of trainings attended by staff
- Staff vacancies
- After-hours contacts and contacts in the community

Review and analysis of this data supports continuous quality improvement processes at the provider and state level, informs decision-making, and helps to identify training and technical assistance needs.

10. Please list the diagnostic categories identified for your state's ESMI programs.

The target population for the CSC initiative is young adults between the ages of 16 and 30 who have been experiencing psychotic symptoms for 24 months or less and who meet criteria for the following psychiatric disorders:

- Schizophrenia
- Schizophreniform Disorder
- Schizoaffective Disorder
- Bipolar Disorder I with Psychotic Features
- Major Depressive Disorder with Psychotic Features
- Delusional Disorder
- Unspecified Schizophrenia Spectrum and Other Psychotic Disorder

Individuals who meet the above criteria and who have a co-occurring substance use disorder may be served by CSC teams. Individuals with moderate to profound intellectual/ developmental disabilities, medical conditions suspected to be the cause of the psychotic symptoms, and substance-induced psychotic symptoms are ineligible for CSC services.

The inclusion in Georgia's CSC programs of peer support specialists for young people, and parent peer support specialists, is viewed by CSC teams as a significant factor in the engagement and retention of program participants and key to instilling a sense of hope in young people and their families at this critical juncture in their lives.

Please indicate areas of technical assistance needed related to this section.

At this time, we do not anticipate any technical assistance needs in this area.

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Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person?s strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person?s goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person?s needs and desires.

1. Does your state have policies related to person centered planning? ☐ Yes ☐ No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

It is the policy of DBHDD to ensure compliance with applicable state and federal laws and regulations regarding confidentiality and privacy of a person's health care information, including information about mental health, developmental disabilities, or substance use disorders.

DBHDD contracted providers and or staff encourage individuals to include their representatives/caregivers, natural and/or paid supports to participate in discussions regarding health care decisions and to enhance communication. It is expected that DBHDD contracted providers and or staff will invite persons to participate in these discussions.

4. Describe the person-centered planning process in your state.

Community services are provided through contracts with private, for-profit, non-profit, and quasi-public agencies, under contract with DBHDD. Individual choice is a value that is embraced throughout the system, and is fostered through the development of different kinds of provider agencies, including consumer operated agencies. These organizations vary in scope of services provided including those services commonly utilized by anyone with a mental illness and those services that address more individualized needs.

An individual's own recovery goals are considered when developing the person centered plan of care and assisting with the linkage to community based services after transition into the community. Once a community service provider is identified, and a release of information is obtained from the individual, the provider is strongly encouraged to actively engage in the transitioning and discharge planning process. The hospital is recovery focused and utilizes the "Individualized Recovery Plan" to guide an individual's treatment and recovery.

For individuals who have taken longer to stabilize (more than 45 days) or who have been readmitted within 30 days of discharge or 3 times in 12 months receive an additional level of transition planning for the individual's successful transition into the community.

DBHDD embraces Georgia's Recovery Definition and Guiding Principles & Values, which best describe the state of Georgia's person-centered planning process.

Georgia's Recovery Definition

• Recovery is a deeply personal, unique, and self-determined journey through which an individual strives to reach his/her full potential. Persons in recovery improve their health and wellness by taking responsibility in pursuing a fulfilling and contributing life while embracing the difficulties one has faced.
• Recovery is not a gift from any system. Recovery is nurtured by relationships and environments that provide hope, empowerment, choices and opportunities.
• Recovery belongs to the person. It is a right, and it is the responsibility of us all.

Georgia's Recovery Guiding Principles & Values

Recovery...

- Emerges from hope
- Is person-driven
- Strengths based
- Age Independent
- Recognizes the wisdom of "lived experiences"
- Occurs via many pathways
- Is holistic
- Is supported by peers, allies, advocates and families
- Is nurtured through relationships and social networks
- Is culturally based and influenced
- Is anchored in wellness- addressing a person's emotional health, environmental well-being, financial satisfaction, intellectual creativity, occupational pursuits, physical activities, social engagement and spiritual health
- Addresses trauma
- Supports self- responsibility
- Empowers communities
- Is based on respect

Please indicate areas of technical assistance needed related to this section.

None at this time.

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DBHDD has engaged the services of trainers and consultants to provide a series of trainings on recovery-oriented service delivery and recovery-focused treatment. This has been instrumental in promoting person-centered, recovery-oriented services throughout our adult behavioral health system.

In February 2019, the National Center on Advancing Person-Centered Practices and Systems (NCAPPS) received 33 applications for technical assistance, and 15 states were selected for the first cohort. Technical assistance recipients work with national subject matter experts toward individualized goals focused on systems change to ensure the person is at the center of service organization and delivery. The Georgia Department of Human Services, Division of Aging Services (DAS) was selected. As a result of ongoing collaboration with DAS, DBHDD was invited to participate as a collaborative partner in the NCAPPS technical assistance process. The project is focused on developing cross-system definitions, language, and policies that will promote enhanced person-centered planning and better coordination of care for mutual clients.

Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf** States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? ☐ Yes No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? ☐ Yes No

3. Does the state have any activities related to this section that you would like to highlight?

   1. Various staff at the Department and Regional level have responsibility for Program Integrity activities that are currently done. Additionally, DBHDD has also developed a list of policies and procedures that are general in nature and applicable to all departments as it relates to managing and monitoring programs that receive Federal award dollars. Additionally, this policy also includes a list of program-specific policies and procedures maintained by the Agency. These policies and procedures have been developed to help ensure that management's directives are carried out as they relate to each applicable OMB compliance requirements. These policies and procedures highlight the control activities and/or internal controls present and describe the proper management of sub-recipient activity.

   2. For those services under contract that are Evidence-based practices, DBHDD staff have implemented fidelity monitoring activities that involve technical assistance and training. Some examples are ACT, Supported Employment and Care Management Entity Services. In addition, through review of monthly programmatic and expenditure reports, staff monitor compliance with contract deliverables.

   3. All providers under contract or letter of agreement with DBHDD must adhere to the Policy, Payment by Individuals for Community Behavioral Health Services, 01-107. This policy applies to organizations under contract, letter of agreement,

memorandum of understanding or service agreement with DBHDD to provide community based Mental Health and Addictive Diseases services. This policy governs services provided to individuals who meet DBHDD established eligibility criteria requirements for mental health and/or addictive diseases services. This policy indicates that DBHDD funds are payment of last resort.

Please indicate areas of technical assistance needed related to this section

None at this time.

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Environmental Factors and Plan

7. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the **2009 Memorandum on Tribal Consultation**[56] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state?s plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

[56] https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

   Georgia does not have any federally recognized tribal governments or tribal lands within the state's borders.

2. What specific concerns were raised during the consultation session(s) noted above?

3. Does the state have any activities related to this section that you would like to highlight?

   N/A

   Please indicate areas of technical assistance needed related to this section.

   N/A

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Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occuring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Georgia's adult mental health state service system includes an array of Core, Specialty, Crisis, and Inpatient services. Adult Mental Health has invested considerable resources to ensure availability of a comprehensive array of intensive, out-of-hospital services including the development of intensive treatment residences, mobile crisis response teams, community based crisis stabilization units, assertive community treatment and community support services, intensive case management as well as psychosocial rehabilitation, peer wellness centers and a host of other community based programming all with the goal of supporting a meaningful life in the community for all of Georgia's citizens. Below are services for adult mental health:

Access and Referral Service

• Many individuals approach the state service delivery system looking for help. Not everyone who seeks assistance needs mental health crisis services. The Georgia Crisis and Access Line is a 24 hour/7 day a week resource for Georgians who need either routine, crisis, or inpatient behavioral health services. The system, which includes mobile crisis services in several counties, provides fast and accurate connections with on-the-spot appointment scheduling for services.

Core Services

• Diagnostic Assessment and Individualized Recovery/Resiliency Planning

Individuals have the opportunity to meet with clinicians, physicians, nurses, peer specialists and care managers to receive comprehensive assessment, a recovery plan built to specification and individual driven and linkage to other community-based services such as housing, employment, whole health planning and support programs. A diagnostic assessment is provided by a physician or advanced practice nurse or physician's assistant trained in psychiatry and includes a bio-psychosocial history, mental status exam, evaluation and assessment of physiological phenomena, psychiatric evaluation, screen for withdrawal if indicated, assessment of appropriateness for service or continuation of service and a disposition.

• Crisis Intervention

Crisis intervention services are available 24 hours per day, 7 days per week, and may be offered by telephone and/or face-to-face in any setting. Services are directed toward the support of an individual who is experiencing an abrupt and substantial change in behavior related to a precipitating situation or a marked increase in personal stress. Crisis services are time-limited and are designed to prevent out of community placement or hospitalization. Interventions are used to de-escalate the situation while facilitating access to a myriad of crisis services when deemed necessary. The individual's behavioral health care advanced directive, if existing, is utilized to help manage the crisis.

• Psychiatric Treatment

Medical evaluation and medication management as well as assessment for appropriateness of treatment and monitoring an individual's status in relation to treatment and medication.

• Nursing Assessment and Health Services

Typically, face to face contact with a licensed nurse who provides nursing assessments to care for physical, nutritional and psychological issues, assess response to medication, consult with individual about medical, nutritional or health related needs, educate about potential side effects, perform venipuncture, provide assessment, testing and referral for an infectious disease.

• Medication Administration

The act of introducing a drug into the body of another person by any number of routes. Medication administration requires a physician's order and is not the supervision of self- administration of medication.

• Pharmacy Services

Either operate or purchase services to order, package, and distribute prescription medications. Assists individuals in accessing medication assistance programs and performs necessary lab work so that an individual is not refused service due to inability to pay.

• Case Management
This service consists of providing support, linkage and care coordination considered essential to assist the individual with improving their functioning, gaining access to necessary services and resources, and creating an environment that promotes recovery as identified in his/her individual recovery plan.

• Psychosocial Rehabilitation- Individual
Services include individual rehabilitative skills building considered essential in improving an individual's functioning level and learning skills that promote his/her access to necessary services and resources.

• Individual Counseling
A therapeutic intervention where in a qualified clinician employs techniques to assist a person in identifying or resolving personal, vocational, intrapersonal and interpersonal concerns.

• Family Training/Counseling
A therapeutic intervention with identified family populations directed toward the achievement of individual specified goals with an anticipated outcome of restoration, development, enhancement or maintenance of processing skills, healthy coping mechanisms, adaptive skills and behaviors, interpersonal skills, family roles and relationships, family understanding of mental illness and/or substance related disorders.

• Group Training/Counseling
Services provided in a group format with a skilled clinician or facilitator to address goals and issues the individual identifies as important to his or her recovery.

Specialty Services
• Assertive Community Treatment
Is a recovery focused, high intensity, community based service for individuals whose past or current response to other community-based intensive behavioral health treatment demonstrated minimal effectiveness, discharged from multiple or extended stays in psychiatric hospitals, frequently seen in emergency rooms, or crisis stabilization units due to SPMI, chronically homeless, and/or released from jails or prisons. A multidisciplinary team provides intensive, integrated and rehabilitative treatment and support within the community, and 24/7 face-to-face services must be available. This service is designed to decrease episodes of homelessness, hospitalizations, incarcerations, emergency room visits, and crisis episodes through comprehensive treatment that promotes community integration.

• Community Support Team
Is an intensive community-based service for individuals in rural areas who cycle in and out of intensive services and have not had their mental health treatment needs met via traditional outpatient services. This service is designed to decrease hospitalizations, incarcerations, emergency room visits, and crisis episodes through community integration. This service includes nursing services, care coordination, individual counseling, and skill building. Working in partnership with the core provider, this service is available 24/7 with emergency response coverage.

• Peer Support Services/Forensic Peer Support Services
Provide structured activities within a peer support center, inpatient hospital, CSC/Temp Observation, correctional facility, probation reporting center, or mental health treatment court that promote socialization, recovery, wellness, self-advocacy, development of natural supports maintenance of community living skills and successful community reintegration

• Psychosocial Rehabilitation-Group
Is a therapeutic, rehabilitative, skill building and recovery promoting service for individuals to gain the skills necessary to allow them to remain in or return to naturally occurring community settings. Services include group skills building, social problem solving and coping skill development, prevocational skills and recreational opportunities. It is offered twenty-five hours a week, for a maximum of 5 hours per Day.

• Supported Employment
Job development, placement and training for individuals with behavioral health challenges who desire competitive employment and need assistance to locate, choose, obtain, learn and maintain a competitive job in an integrated setting. Services include vocational interest and skills assessment, job search and maintenance supports that are necessary to perform and retain a particular job.

• Intensive Case Management
This is a recovery focused community approach that assists individuals with complex and high intensity care coordination of

service needs with moving between and among services necessary in order to remain in the community. Primary functions of this service include assessment of need, recovery planning, care coordination, access to resources, and monitoring. With a low staff to client ratio and a focus on rehabilitation, interventions are delivered primarily in the community rather than in office settings in order to coordinate needed mental health, physical health, and social services to support the individual's recovery process.

• Intensive Residential Services
Provides around the clock awake staff to assist individuals in successfully maintaining housing stability within the community, continue with their recovery, and increase self-sufficiency. A minimum of five hours of skills training is delivered each week to each individual enrolled.

• Semi-Independent Residential Services
The semi-independent residential service provides on-site staff available to deliver personal support and skills training at least 35 hours per week to each individual.

• Independent Residential Services
Scheduled residential services to an individual who requires a low level of residential structure to maintain stable housing. While there must be a written emergency plan that gives individuals access to a residential service specialist 24/7, the service requires a minimum of one face to face encounter per week.

• Housing Vouchers
The Georgia Housing Voucher assists individuals with an SPMI categorization in attaining and maintaining safe and affordable housing and supports their integration into the community. Supported Housing includes integrated, permanent housing with tenancy rights, linked with flexible community-based services that are available to individuals when they need them, but are not mandated as a condition of tenancy. All individuals with financial means are required to contribute a portion of their income towards their living expenses (tenant paid utilities, rent, and initial start-up expenses).

• Projects for Assistance in Transitioning from Homelessness (PATH)
PATH is a SAMHSA grant funded program designed to support the delivery of outreach and case management services to individuals with serious mental illness and those with co-occurring substance use disorders who are homeless or at imminent risk of becoming homeless. PATH's homeless outreach teams in Atlanta, Marietta, Columbus, Augusta, Valdosta, and Savannah outreach into the streets and homeless shelters to identify people who are chronically homeless and highly vulnerable to health risks. The teams use assertive engagement strategies to help people access housing and resources needed to end their homeless cycle.

Crisis Services
• Mobile Crisis
This service provides community-based face-to-face crisis response 24 hours a day, seven days a week to individuals in an active state of crisis that threatens their safety. Interventions include a brief, situational assessment; verbal interventions to de-escalate the crisis; assistance in immediate crisis resolution; mobilization of natural support systems; and referral to alternate services at the appropriate level.

• Crisis Stabilization Unit
A residential alternative to inpatient hospitalization, crisis stabilization programs offer psychiatric stabilization and detoxification services through medically monitored services to include psychiatric medical assessment, crisis assessment, support and intervention, medication administration, management and monitoring, brief individual, family or group counseling and medically monitored residential substance detoxification (ASAM level III.7-D.)

• Crisis Respite Apartments
Crisis respite apartments offer a brief period of respite for individuals needing a supportive environment. This service is available for individuals who are transitioning back into the community from a psychiatric inpatient facility, crisis stabilization unit (CSU) or behavioral health crisis center (BHCC)a. Crisis respite apartments include individualized engagement, connection to crisis planning, linkage to treatment, and other community resources necessary for the individual to safely reside in the community.

Inpatient Services
• State Operated Psychiatric Hospitals
DBHDD maintains accredited state operated psychiatric hospitals that provide intensive inpatient services for individuals who present an "imminent danger to self or others".

• Community Based Inpatient Psychiatric and Substance Detoxification Services
This is a short term stay in a licensed and accredited community-based hospital for the treatment or habilitation of a psychiatric and/or substance abuse disorder. Georgia is moving away from hospital settings and toward social detoxification, assertive community treatment teams, mobile crisis response teams and crisis stabilization programs.

Substance Use Disorder Services

Substance Use Disorder treatment and recovery support services are contracted through Tier 1, Tier 2, Tier 2+ and specialty providers statewide. By contract, all providers offering the core benefit package must be co-occurring capable. Georgia provides

the following service array;

- Outpatient
- Residential
- CSU crisis services
- Detoxification
- Women's Treatment and Recovery Support Services (outpatient, residential and transitional)
- HIV EIS
- Peer Support services
- Addictive Disease Support Services
- C&A Clubhouses
- C&A IRT
- Adult Recovery Centers
- Opioid Maintenance Treatment

Child and Adolescent Mental Health Services
DBHDD provides a comprehensive community-based system of mental health care for children and adolescents with serious emotional disturbances (SED) and their families who need public services.
Below are brief descriptions of services provided to children and adolescents:

C&A Non-Intensive Outpatient Services
- Behavioral Health Assessment

Face-to-Face comprehensive assessment with the individual that includes the individual's perspective (and that of family and significant others as well as collateral agencies/treatment providers).

- Diagnostic Assessment

Psychiatric diagnostic interview examination completed in a face-to-face format (which may include the use of telemedicine) and may include family and other sources.

- Psychological Testing

Face-to-face assessment of emotional functioning, personality, cognitive functioning or intellectual ability using objective and standardized tools that have uniform procedures for administration and scoring, and utilizes normative data upon which interpretation of results is based.

- Crisis intervention

Designed to prevent out of home placements or hospitalization. Time-limited and present-focused in order to address the immediate crisis and develop appropriate links to alternate services.

- Medication Administration

An assessment, by the licensed or credentialed medical personnel administering the medication, of the youth's physical, psychological and behavioral status in order to make a recommendation regarding whether to continue the medication and/or its means of administration, and whether to refer the youth to the physician for a medication review. Education to the youth and/or family/responsible caregiver(s), by appropriate licensed medical personnel, on the proper administration and monitoring of prescribed medication in accordance with youth's resiliency plan, must also be included.

- Nursing Assessment and Health Services

Requires face-to-face with youth/family/caregiver to monitor, evaluate, assess, and/or carry out a physician's orders regarding the psychological and/or physical problems and general wellness of the youth.

- Psychiatric Treatment

The provision of specialized medical and/or psychiatric services, including medication management and psychiatric psychotherapy, assessment, and monitoring, performed by a Board-Certified medical doctor licensed in the State of Georgia.

- Community Support

Rehabilitative, environmental support and resource coordination considered essential to assist a child/youth and family in gaining access to necessary services and in creating environment that promote resiliency and support the emotional and functional growth and development of the child/youth.

- Family Counseling

A therapeutic intervention or counseling service (successful with family populations) directed towards specific goals defined by youth and parent(s)/responsible caregiver(s) conducted by licensed staff, and specified in the Individualized Resiliency Plan.

• Family Training

Systematic interactions between identified individual, staff, and family directed towards restoration, development, enhancement, or maintenance of functioning of individual/family unit. This may include support of family, as well as training and specific interventions/activities to enhance family roles, relationship, communication and functioning promoting resiliency of family unit. This is directed toward the achievement of specific goals defined by the youth, parent(s), or responsible caregiver(s).

• Group Counseling

Group based therapeutic intervention or counseling service successful with populations, diagnoses, and needs. Directed toward the achievement of specific goals defined by the youth and by the parent(s)/responsible caregiver(s).

• Group Training

Services may address goals/issues such as promoting resiliency, and the restoration, development, enhancement or maintenance of such things as problem solving skills, illness and medication self-management knowledge and skills, and healthy coping mechanisms.

• Individual Counseling

A therapeutic intervention or counseling service shown to be successful with identified youth populations, diagnoses, and service needs, provided by a qualified clinician. Techniques employed involve principles, methods, and procedures of counseling that assist the youth in identifying and resolving personal, social, vocational, intrapersonal, interpersonal concerns.

• Service Plan Development

Development of the Individualized Recovery/Resiliency Plan based on the results of the Diagnostic and Behavioral health assessments. Plan is required within the first 30 days of service.

• Community Transition Planning

Community Transition Planning (CTP) is a service provided by Tier 1, Tier II and IFI providers to address the care, service, and support needs of youth to ensure a coordinated plan of transition from a qualifying facility to the community. Each episode of CTP must include contact with the individual, family, or caregiver with a minimum of one (1) face-to-face contact with the individual prior to release from a facility. Additional Transition Planning activities include: educating the individual, family, and/or caregiver on service options offered by the chosen primary service agency; participating in facility treatment team meetings to develop a transition plan

Specialty Services

• Intensive Family Intervention

Services intended to improve family functioning by clinically stabilizing the living arrangement, promoting reunification, or preventing the utilization of out-of-home therapeutic venues for the identified youth. Services are delivered utilizing a team approach and are provided primarily to the youth in their living arrangement and within the family system. This service includes crisis intervention, intensive supporting resources management, resource coordination, individual and/or family counseling/training, and other rehabilitative supports to prevent the need for out-of-home placement or other more intensive/restrictive services.

• Child and Adolescent Structured Residential Supports

Formerly Rehabilitation Supports for Individuals in Residential Alternatives, Levels 1 & 2, are comprehensive rehabilitative services to aid youth in developing daily living skills, interpersonal skills, and behavior management skills; to enable youth to learn about and manage symptoms; and aggressively improve functioning/behavior due to SED, substance abuse, and/or co-occurring disorders.

• Crisis Stabilization Units

This is a medically monitored residential treatment alternative to, or diversion from, inpatient hospitalization, offering short-term psychiatric stabilization and detoxification services.

• Community Based Inpatient Psychiatric and Substance Detoxification Services

A short-term stay in a licensed and accredited community-based hospital for the treatment or habilitation of a psychiatric and/or substance related disorder.

• Mobile Crisis

This service provides time-limited crisis intervention in the community to reduce escalation of a crisis situation, relieve the immediate distress of individuals experiencing a crisis situation, reduce the risk of individuals doing harm to themselves or others, and to promote timely access to appropriate services for those who require ongoing mental health and co-occurring mental health and substance abuse services. This service is available 24 hours per day, seven days per week.

• Parent Peer Support Service- Group

This is a strength-based rehabilitative service provided to parents/caregivers in order to promote recovery by increasing the

family's capacity to function within their home, school, and community. Services are rendered by a Certified Peer Support-Parent

(CPS-P) and uses a group format.

• Parent Peer Support Service- Individual
This is a strength-based rehabilitative service provided to parents/caregivers in order to promote recovery by increasing the family's capacity to function within their home, school, and community. Services are rendered by a Certified Peer Support-Parent (CPS-P) and uses an individual format.

• Youth Peer Support- Individual
This is a strength-based rehabilitative service provided to youth who are living with a mental health, substance use, and/or co-occurring health condition. This one-to-one service rendered by a Certified Peer Support-Youth (CPS-Y) models' recovery by using lived experience as a tool.

• Psychiatric Residential Treatment Program (PRTF)
Psychiatric Residential Treatment Facility (PRTF) services provide comprehensive mental health and substance abuse treatment to children, adolescents, and emerging adults from ages six through twenty-one who, due to severe emotional disturbance, are in need of quality active treatment that can only be provided in an inpatient treatment setting and for whom alternative, less restrictive forms of treatment have been tried and found unsuccessful, or are not medically indicated. PRTF programs are designed to offer intensive, focused treatment to promote a successful return of the youth/emerging adult to the community.

• Intensive Customized Care Coordination
Intensive customized Care Coordination is a provider-based High-Fidelity Wraparound intervention, as defined by the National Wraparound Initiative, comprised of a team selected by the family/caregiver in which the family and team identify the goals and the appropriate strategies to reach the goals. Intensive Customized Care Coordination assists individuals in identifying and gaining access to required services and supports, as well as medical, social, educational, developmental and other services and supports, regardless of the funding source for the services to which access is sought.

• Clubhouse Services
Resiliency Support Clubhouse Services for children and youth (ages 6-21) with behavioral health needs has been modeled after its counterpart within addictive diseases. These Resiliency Support Mental Health Clubhouses are designed to provide a comprehensive and unique set of services for children and families coping with the isolation, stigma, and other challenges of mental health disorders.

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

a)	Physical Health	☐ Yes	No
b)	Mental Health	☐ Yes	No
c)	Rehabilitation services	☐ Yes	No
d)	Employment services	☐ Yes	No
e)	Housing services	☐ Yes	No
f)	Educational Services	☐ Yes	No
g)	Substance misuse prevention and SUD treatment services	☐ Yes	No
h)	Medical and dental services	☐ Yes	No
i)	Support services	☐ Yes	No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	☐ Yes	No
k)	Services for persons with co-occuring M/SUDs	☐ Yes	No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

Georgia continues to advance evidence-based practices and promising practices. DBHDD has focused considerable attention on developing and implementing evidence-based practices within the mental health service system through dissemination of information and through pilot demonstration projects. As a result of this emphasis on best practice, the mental health system in Georgia has implemented Evidence-Based Practices (EBPs) in various parts of the state. The EBPs used within the state include Assertive Community Treatment (ACT), Individual Placement and Support (IPS) Supported Employment, Motivational Interviewing (MI), Housing First Permanent Supported Housing, and Integrated Dual Diagnosis Treatment (IDDT). Georgia's gender specific and age specific substance use treatment programs use evidence-based practices and fully integrates both mental health and substance use issues in the individualized recovery plan of those individuals who identify substance use as a barrier to recovery. DBHDD has spent several years providing statewide training to ensure competency in assessing and treating both mental illness and substance use disorders. In addition, Georgia has been a leader in the development of Peer Support Services and has implemented a Forensic Peer Mentor

initiative. DBHDD also contracts for the delivery of an array of crisis services. All of these services provide for a system of care for adults, support recovery of individuals, and provide opportunities for a meaningful life in the community. DBHDD currently contracts with providers for statewide delivery of ACT services in all 6 regions in the state of Georgia with funding and support for 22 state contracted and four Medicaid Rehabilitation Option (MRO) teams. DBHDD's contracted SE providers are funded to serve a total of 1,575 individuals each month. Since the significant FY15 increase in SE service capacity the department has continued to implement provider training on evidence-based practice SE (EBP SE) also known as the Individual Placement & Support (IPS) Model. Training has been delivered to contracted Supported Employment providers on Mental Health First Aid. Technical assistance was also provided during onsite IPS fidelity reviews of DBHDD's contracted providers.

DBHDD provides supported housing using the Housing First model. DBHDD is now the 8th largest provider of rental assistance in the state. As important as it is to assist individuals in obtaining safe and stable housing, it is equally vital to offer the supports and access to services that will help someone maintain their housing. This is the beauty of our system; DBHDD has a network of dedicated, hardworking behavioral health community service providers who deliver Community Support Team (CST) and Assertive Community Treatment (ACT) and Intensive Case Management (ICM) for persons with serious mental illness, supporting people with skills building and recovery planning in a way that helps people remain stable and housed in their community.

Georgia offers an array of Peer Support Services. Peer Support Programs provide structured group activities that are provided between and among individuals who have common issues and needs; are person-motivated, initiated and/or managed; and assist individuals in living as independently as possible.

For child and adolescent mental health, DBHDD OCYF has a school-based mental health services program, known as the Georgia Apex Program, which was developed in order to enhance access to the appropriate level of care; to provide early detection of child and adolescent behavioral health needs; and to develop and sustain coordination and collaboration between Georgia's community mental health providers and the school districts in their service areas. Georgia Project AWARE (GPA), funded by the Substance Abuse and Mental Health Services Administration, is designed to make schools safer and increase access to mental health services for children and youth. Both the State and the participating school districts have made an excellent start in addressing the mental health needs of children, youth, families and caregivers. The multiple components of the project including universal mental health screenings, a mental health referral process, Youth Mental Health First Aid (YMHFA) and school-based mental health services. Project Aware has worked collaboratively with DBHDD's Apex project and trained together on the Interconnected Systems Framework (ISF), an integration of mental health into the Positive Behavioral Interventions and Supports framework.

Project LAUNCH (Linking Actions for Unmet Needs in Children's Health), another SAMHSA funded grant, continues efforts to increase access to screening, assessment, and referral for appropriate services for children ages 0-8 in Muscogee County. DBHDD is partnering with the Department of Public Health (DPH) to implement the strategic plan. The project is currently focused on increasing mental health screening of young children in the school and early education settings using the ASQ and ASQ – SE (Ages and Stages Questionnaire – Social Emotional Assessment), increasing outreach to pediatricians to include mental health screening in their processes, and training the young child workforce on the social emotional development of young children. These goals are being accomplished through many local partnerships and the project has been able to establish many family, physician and community service champions.

In addition, DBHDD OCYF has two initiatives targeted to youth and young adults of transition age. The TAYYA initiative was designed to increase cooperation and collaboration across agencies to meet the needs of TAYYA with serious mental health conditions and their families. Funds available further the work of building infrastructure for non-billable time related to enhance outreach and engagement to emerging adults and build youth leadership/advocacy skills that is not reimbursable through Medicaid or other funds. They support best practices, cultural competence, support services that assist youth with independent living address needs for housing, employment, education, basic living skills, and social support not supported by other funding. The Emerging Adult Support Services (EASS) initiative is designed to create developmentally-appropriate and effective youth-guided local systems of care to improve outcomes for emerging adults with serious mental health conditions in areas such as education, employment, housing, mental health, and co-occurring disorders, and decrease contacts with the criminal justice system. OCYF supports EASS grants to Comprehensive Community Providers and "Not for Profit" providers to meet the following objectives: 1) Increase and improve cooperation and collaboration across agencies to meet the multiple and complex needs of emerging adults with serious mental health conditions and their families; 2) Enhance outreach and engagement to emerging adults and build youth leadership/advocacy skills; 3) demonstrate improving access and expanding the array of community-based, age-appropriate treatment, culturally and linguistically competent services and supports for emerging adults as well as their families.

DBHDD has also provided funding support to providers of child and adolescent mental health services for purposes of supporting activities that build on system of care infrastructure and support in local communities. DBHDD OCYF also provides funds for the System of Care Enhancement and Expansion Initiative. These awards are used to support system of care value oriented in child and adolescent mental health. These monies further the work of building infrastructure for

non-billable time related to family team meetings, LIPT meetings, and other consultative services with the other child serving agencies that are not reimbursable through Medicaid or other funds.

They support best practices, cultural competence, training, outreach activities to engage families, Non-Medicaid, non-billable transportation to and from treatment related activities, supplies and activities for individuals during groups and programming, community education activities on system of care work, and engagement activities with youth not supported by other funding.

The Office of Addictive Diseases (OAD) provides Core and Specialty Services. In addition, OAD continues to increase the array of treatment services available for youth with substance abuse issues. The services are: intensive residential treatment programs (IRTs) and the clubhouse recovery support services for youth. In addition, DBHDD funds two Adolescent Intensive Residential Treatment (IRT) Programs. The IRTs provide 24-hour supervised residential treatment for adolescents ages 13-17 who need a structured residence due to substance use disorders.

3. Describe your state's case management services

For adults with SMI, there are two types of case management: case management and intensive case management. Case Management consists of providing support, linkage and care coordination considered essential to assist the individual with improving their functioning, gaining access to necessary services and resources, and creating an environment that promotes recovery as identified in his/her individual recovery plan. Intensive Case Management is a recovery focused community approach that assists individuals with complex and high intensity care coordination of service needs with moving between and among services necessary in order to remain in the community. Primary functions of this service include assessment of need, recovery planning, care coordination, access to resources, and monitoring. With a low staff to client ratio and a focus on rehabilitation, interventions are delivered primarily in the community rather than in office settings in order to coordinate needed mental health, physical health, and social services to support the individual's recovery process.

For children and adolescents two types of case management services are offered: Community Support and Intensive Customized Care Coordination. Community Support is rehabilitative, environmental support and resource coordination considered essential to assist a child/youth and family in gaining access to necessary services and in creating environment that promote resiliency and support the emotional and functional growth and development of the child/youth. Intensive customized Care Coordination is a provider-based High-Fidelity Wraparound intervention, as defined by the National Wraparound Initiative, comprised of a team selected by the family/caregiver in which the family and team identify the goals and the appropriate strategies to reach the goals. Intensive Customized Care Coordination assists individuals in identifying and gaining access to required services and supports, as well as medical, social, educational, developmental and other services and supports, regardless of the funding source for the services to which access is sought.

4. Describe activities intended to reduce hospitalizations and hospital stays.

Via contract with DBHDD, Behavioral Health Link (BHL) operates the Georgia's Crisis and Access Line (GCAL). GCAL's professional, clinical staff provide 24/7 telephonic crisis intervention and linkage to DBHDD services state-wide through a toll-free, confidential hotline available 24 hours a day, 7 days a week from anywhere in Georgia. It connects callers with a trained, professional who can help them get the services they need if they or someone they know or are caring for are in emotional distress, behavioral health crisis, a suicidal crisis, or even a crisis related to an intellectual/developmental disability.

Crisis stabilization units, behavioral health crisis centers, mobile crisis services and assertive community treatment assist persons through acute crises while remaining in the community. Although each of the six DBHDD regions has access to psychiatric hospital services for acute inpatient care for adults requiring hospital treatment, utilization of inpatient treatment is closely monitored. Every effort is made to prevent hospitalization through increased reliance on Community Crisis Stabilization Units (CSU), Crisis (walk-in) Service Centers (CSC), Behavioral Health Crisis Centers (CSC, Temporary Observation Unit, and CSU all on the same campus), and Crisis Respite Services. A network of Crisis Stabilization Units is spread across the state to help individuals in need of intensive interventions including; rapid assessment, stabilization, observation or brief admission. In community settings, the focus of CSU/BHCCs is provision of assessment, stabilization, medication monitoring, nursing services, linkage and referral and other treatments to support the individual in quickly returning to their own home in the community.
When individuals with SMI are hospitalized, they are offered peer support services from a Peer Mentor, who can assist them to actively engage in discharge planning and in making the transition to their new community home. Peer Mentors can help individuals set up household and make solid connections with service providers, and any other groups in the community with whom the individual would like to engage/participate.

The Hospital Recovery Planning Teams, Regional Field Office staff and Office of Adult Mental Health Transition Services are responsible for effective transition planning. This planning requires the development of partnerships between individual's hospital staff, field office staff and community care providers. All aspects of person-centered recovery planning rely on shared decision making and individually defined outcomes. Hospital Transition Specialists and Community Case Expediters in the Regional Field Offices are key players who rely on relationships they have established through collaborative efforts to help facilitate individuals obtaining needed services, and in crisis situations, can often divert individuals from the hospital to appropriate resources in the community. Hospital Transition Specialists and Community Case Expediters are perceived as the link between the hospitals and the community.

As it relates to children and adolescents, DBHDD has worked, successfully, to move from heavy reliance on acute care hospital services to increased community services. To that end, all state-operated long-term and short-term hospital units were closed some years ago. Comprehensive Community Providers (CCPs) are required to provide crisis services for youth receiving services. In addition, youth in need of acute care, crisis stabilization and treatment are being served through the array of Crisis Stabilization Units (CSUs) and mobile crisis services.

Narratve Question

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	393,035	138,551
2.Children with SED	99,707	46,463

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

Prevalence estimates based on Federal CMHS estimating methodology. For adults with SMI, the prevalence rate of 5.4% is multiplied by the total adult population age 18 and over. For children and adolescents with SED, the prevalence rate of 8% is multiplied by the total child and adolescent population ages 9-17. For adults with SMI needing services from the public sector, Incidence is based on the % of population 18 and over under 200% of poverty. For children and adolescents with SED needing services from the public sector, incidence is based on the % of population ages 9-17 under 200% of poverty.

Narratve Question

Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for their multiple needs.

Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care?

a)	Social Services	☐ Yes	☐ No
b)	Educational services, including services provided under IDE	☐ Yes	☐ No
c)	Juvenile justice services	☐ Yes	☐ No
d)	Substance misuse preventiion and SUD treatment services	☐ Yes	☐ No
e)	Health and mental health services	☐ Yes	☐ No
f)	Establishes defined geographic area for the provision of services of such system	☐ Yes	☐ No

Criterion 4

a. Describe your state's targeted services to rural population.

Five of the six DBHDD regions have rural areas. As such, service to persons living in rural localities is of primary concern. Mental health service planning for rural areas occurs at a local level through the six DBHDD Field Offices. Field Offices, through input from their Regional Advisory Councils, public forums, public surveys, focus groups, and youth and family satisfaction surveys gather information to better plan for services in all areas of the state, particularly rural areas.
DBHDD contracts with providers to cover all areas of the state. Increasing access to services has been a major thrust of the DBHDD and its Regional Offices. Providers are required to deliver services out of the clinic setting. The Georgia Crisis and Access Line (GCAL) provides people seeking behavioral health services with information and access to comprehensive outpatient and crisis services throughout the state.

Transportation, however, can be a challenge. Medicaid enrolled individuals are able to utilize Medicaid transportation systems for travel to services; however, transportation services remain a challenge in more rural areas. Because many individuals with behavioral health needs lack access to natural supports to assist them in traveling to services many miles away from their homes, funding for transportation to Settlement services was approved by State legislators as a part of the original Department of Justice ADA Settlement Agreement. DBHDD has entered into a contract with the Department of Human Services to provide state supported transportation for individuals receiving the intensive community adult mental health services including: ACT, CST, CSU, ICM, CM, and Supported Employment services.

The Medicaid State Plan approved in May 2017 includes a new Consultation code approval to allow Tier I and Tier II BH Providers to bill when they engage with practitioners external to the system. The goal of the service is to allow these providers to access external and remote medical professionals to 1) promote health integration and 2) to access remote medical specialists to support and or refine diagnosis, prescribing, and treatment. This will assist rural providers in accessing specialists in other communities to support the individuals in those rural areas. Telemedicine continues to be an emerging avenue for dealing with the shortage of physicians and other practitioners in rural areas and Georgia is exploring additional ways to promote the effective use of telemedicine into the system of care. DBHDD worked with the State Medicaid Authority to add a rural modifier to ACT to promote statewide availability of ACT-type services. Therefore, DBHDD offers Community Support Teams (CST) to individuals living in rural areas.

Georgia continues to heavily invest in its Certified Peer Specialist workforce to promote recovery-based support capacity. In order to promote access, DBHDD has expanded CPS certification courses from metro Atlanta to the southern part of the state to promote rural workforce expansion. Additionally, the majority of peer wellness centers are located in rural communities and there are peer warm lines that operate 24/7. This is in addition to the GCAL which also operates 24/7 providing access to clinicians.

As relates to children and adolescents, one of the initiatives put forward by DBHDD to expand services throughout the state, including rural areas, is a school-based mental health project. This effort mentioned previously is referred to as Georgia Apex. DBHDD provides grant funding to 24 Community Service Boards and three additional providers to support the integration of community mental health professionals in the learning environment of targeted schools. Focusing on disparate populations, as well as local schools with identified need around school climate, the overarching goal is to increase access to mental health services and to ensure increased and sustained coordination between community mental health providers and local education agencies.

b. Describe your state's targeted services to the homeless population.

DBHDD has participated in collaboratives focused on homelessness. The Assistant Director of Adult Mental Health has been DBHDD's primary contact. In addition, to past involvement with coalitions in Georgia to address homelessness, she is a current member of the NASMHPD Housing Task Force. She also recently participated in the United States Interagency Council on Homelessness (USICH) Criteria and Benchmarks for Ending Family Homelessness: Stakeholder Input Session #3 (June 8, 2017). She is also responsible for PATH implementation.

It is the overall goal of the Projects to Assist in Transition from Homelessness (PATH) program to effectively and efficiently reduce homelessness for individuals with mental illness who do not access traditional mental health services on their own. The primary functions of PATH program are to identify, engage, and link homeless individuals to mainstream mental health services, housing resources, and other needed community resources. The strategy of linking engaged individuals to mainstream providers, rather than establishing a parallel service system for homeless individuals, conserves Georgia's scarce mental health resources. The success of the transition of individuals from PATH programs to mainstream services requires a good relationship between PATH funded agencies and mainstream agencies. PATH funding supports outreach services that goes into communities to identify and engage "literally" homeless individuals who are unable or unwilling to access mainstream mental health services on their own.

Georgia uses hired Certified Peer Specialists with homeless experiences to share their personal story of recovery to help establish client rapport and a client commitment to change. A large percentage of those receiving PATH services are successfully transitioned into mainstream service systems where they receive the resources necessary to end their homelessness. It is Georgia's vision for FY16 through FY18 to increase PATH effectiveness at ending homelessness for adults with mental illness. PATH Teams use the vulnerability index survey developed by Common Ground Institute, to identify those most at risk of dying on the street within one year to mobilize action to access housing and services. PATH Teams are encouraged to directly link those chronically homeless who are identified as most "at risk" to ACT Teams.

In partnership with the Department of Community Affairs (DCA), DBHDD works with core providers to identify target populations and areas of the state in need of Shelter plus Care housing. DBHDD also helps to establish supportive housing using Housing Choice and 811 Program vouchers and attaching mental health services and supports for those individuals who choose them. This has been an effective collaboration that helps individuals who are homeless to access safe, decent and affordable housing and receive community-based recovery services.

Providers are required to gather information on living situation upon enrollment in services. Providers under contract or agreement with DBHDD provide early intervention and mental health treatment services to identified youth with SED and their families who are at risk for homelessness or homeless and ensure that appropriate interventions are provided to meet the needs of this high-risk target population in Georgia. The Core Customer definition for eligibility for services identifies priority groups for state funded services. Youth who are homeless and who are at risk of homelessness are included in the priority group targeted for state funded services. Comprehensive mental health services are available in all regions for children and adolescents with SED who are homeless.

The DBHDD Regional Field Offices and their providers also participate in and support local efforts related to improving service delivery to homeless individuals.

c. Describe your state's targeted services to the older adult population.

The DBHDD Community MH Services Director and the Director of the Division of Aging Services (DAS) both served as members of the state team to develop plans to improve access to all services needed by older adults in Georgia and helped establish Georgia's network of Aging and Disability Resource Connections to serve as an entry way to long-term care support services for individuals with disabilities and the elderly. The goal for mental health improvement is to enhance the coordination and delivery of mental health services for older adults as it relates to the screening, referral, and treatment of mood disorders, primarily depression, as well as anxiety and co-occurring disorders.

DBHDD participates in the Georgia Coalition on Older Adults and Behavioral Health (GCOABH).
The Georgia Mental Health Consumer Network, the Fuqua Center for Late Life Depression, the DAS, and DBHDD partnered to develop a curriculum and trained Peer Specialists to work with older adults with mental illness on whole-health goals and activities.
The Department of Community Health utilizes a network of DBHDD behavioral health providers to deliver mental health services to nursing facility applicants and residents authorized through the Pre-Admission Screening and Resident Review (PASRR) Program. This brought DBHDD providers into the geriatric services market and, thus, encouraged development of expertise and capacity. Many of these same providers also deliver various home and community-based services to individuals in the DAS community Care Services Program who otherwise need institutional care in a nursing facility and who qualify or potentially qualify for Medicaid.

Currently, DBHDD has a Memorandum of Understanding with The Carter Center and the Fuqua Center for Late-Life Depression/Department of Psychiatry and Behavioral Sciences of Emory University to facilitate ongoing cross training of staff at DBHDD, its contracted behavioral health treatment providers, and DAS network of aging services providers in order to strengthen the existing system of care that serves older adults who have a mental illness or co-occurring disorder.

Narratve Question

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

Describe your state's management systems.

Fiscal Resources

The FY20 total annual budget for adult mental health in Georgia is $457,387,413 million. Of the total adult mental health budget, about 86% goes to fund community- based services. The remainder funds state hospitals. Of the adult budget 97% comes from state dollars, and 3% of adult community mental health is funded with federal dollars.

As part of the ADA Settlement Agreement, in FY12, DBHDD was appropriated $32,013,761 in the amended budget for the last quarter of the fiscal year; for FY 13 appropriated $52,356,013; in FY14 appropriated $73,913,477; in FY15 appropriated $97,997,387; in FY16 $2,313,015; in FY17 $6,133,276; in FY18 $7,756,876; and in FY19 the Department was appropriated $5,721,600. These funds support the expansion of community-based mental health services. In addition, part of this funding supports community transition needs of consumers being discharged from the state hospitals, particularly some transportation funds, etc., and there is increased staff capacity to meet the obligations of the Settlement Agreement.

The total amount of Mental Health Block Grant funding available for adult mental health services and administration in SFY20 is $15,178,419, and of this amount, $14, 421,645 is provided for Supported Employment, Peer Support Services and Mental Health Treatment Courts. An additional $783,016 is available to support other activities such as provider training, Georgia Mental Health Consumer Network for Peer Mentor development, the Peer Specialist Training and Certification Program, support to the Georgia Behavioral Health Planning and Advisory Council and state administration.

Over $60 million dollars is available to fund child and adolescent mental health services. Funding has supported an expansion of services including traditional outpatient services, community support, school-based mental health services, intensive family intervention services, mental health clubhouses, mobile crisis and crisis stabilization units. Historically, the majority of state and federal mental health block grant funds were allocated via contracts primarily to public providers of mental health services for the range of community-based mental health services. With the change to an FFS model for children and adolescents, DBHDD primarily has provider agreements for services and fewer contracts with grant in aid allocations.

For SFY20, there is $6,683,546 of MHBG funds available to support child and adolescent mental health services and administration. The majority of funding, $6,232,985 provided for child and adolescent services is contracted and supports the delivery of Care Management Entity Services (CME), Mental Health Clubhouses, a transitional age youth and young adult peer center, and first episode psychosis programs. The remaining amount of $450,561 is used to support training of providers and to support further development of family support/network organizations.

Staffing and Training

Community behavioral health services in Georgia are provided through a number of contracted public and private provider agencies. These are not state agencies and therefore we do not have specific knowledge about the numbers of staff of differing professional disciplines that are employed by each agency. Staffing requirements for services within the Georgia Behavioral Health system are established in both the DBHDD Provider Manual for Community Behavioral Health Services and the Medicaid Services Manual. Practitioners are divided into Professional and Paraprofessional categories and licensed mental health, practice under the scope of relevant practice laws. Paraprofessionals are those practitioners who are not licensed or certified to practice independently and all paraprofessionals must complete a standardized curriculum approved by the Department of Community Health and DBHDD. The training curriculum, Relias Learning (online learning), as a training tool for preparing paraprofessionals to work in the field of mental health; all paraprofessionals are required to complete a list of required courses shortly after hire. Demonstrated mastery of each topic area within the Standard Training Requirement is necessary in order for paraprofessionals to provide either state-funded or Medicaid-reimbursable services in Georgia. This training curriculum includes courses such as Coordinating Primary Care for Needs of Clients; Mental Health Issues in Older Adult Populations; Cultural Issues in Mental Health Treatment for Paraprofessionals; Bipolar Disorder in Children and Adolescents, Overview of Family Psycho Education – Evidence based Practices, Alcohol and the Family for Paraprofessionals, Co-Occurring Disorders; and an Overview for Paraprofessionals, Suicide Prevention, and Suicide the Forever Decision.

Each service definition contains specific staffing patterns that include the required level of supervision by a licensed practitioner, as well as staff-to-consumer ratios that meet standards of care. Urban areas of the state generally have more access to all categories of professional staff. The Health Resources Services Administration (HRSA) has designated many parts of the state as "Health Professional Shortage Areas," highlighting the fact that recruiting and retaining qualified staff presents a continuous challenge to rural providers. While shortages of all levels of professional staff exist within the Georgia system, concerted efforts are being made to secure qualified staff for services provision. Georgia strategically continues to grow the guild of Certified Peer Specialists to assist in promoting access and engagement while the workforce shortage persists. There is a shortage of Child Psychiatrists and psychiatric nurses in Georgia. Nurses and social workers are also under-represented within the public mental

health system, causing providers to focus significant resources on recruitment and retention activities. While shortages of all levels of professional staff exist within the Georgia system, concerted efforts are made to secure qualified staff for services provision.

According to the Georgia Composite Board there are 6,800 Professional Counselors; 872 Marriage and Family Therapists; 3,878 licensed Clinical Social Workers; 2, 732 licensed master's level Social Workers; 114 Associate Marriage and Family Therapists; 1,454 Associate Professional Counselors; and 2,382 Licensed Psychologists. Many rural counties report lack of child and adolescent psychiatry services. In addition, in looking at recent graduates in 2017 from the University System of Georgia, there were 354 graduates in Social Work; 40 graduates in Marriage and family Therapy; 12 graduates in Psychiatric Nursing; 3237 graduates in School Counseling; and 9 graduates in Clinical Psychology.

DBHDD has actively sought to improve its workforce to better deliver quality services. The driving force of DBHDD's system transformation is the continued development of the certified peer workforce. Agents of recovery and transformation, Georgia's CPSs inspire and support adult mental health individuals to recognize their dreams, preferences and strengths, and to learn skills to take responsibility for their recovery and creation of a meaningful life. Certified Peer Specialists (CPSs) have added tremendous value to the workforce as trained recovery specialists. CPSs are required staff for Assertive Community Treatment teams, Core Services and Peer Supports and Coordinated Specialty Care teams for the LIGHT-ETP for first episode psychosis. In addition, they are recommended staff for Psychosocial Rehabilitation. Certified Addiction and Recovery Empowerment Specialist (CARES) teaches individuals how to use their lived experience with recovery from substance use to support their peers in recovery. Individuals who complete the 40-hour experiential classroom work and pass the certification test become CARES. CARES and provide peer support services to people with substance use disorders in Georgia's continuum of care. Georgia also developed a training and certification process for parents of youth with behavioral health conditions. Individuals who complete this course and certification work as Certified Peer Specialists for Parents (CPS-P) in Georgia's continuum of care for children, youth and families. A curriculum has also been developed to certify peer specialists to work with youth (CPS-Y).

DBHDD recognizes the critical importance of staff development and training in strengthening mental health services in Georgia. The Offices of Adult Mental Health and Children, Young Adults and Families in conjunction with the Office of Human Resources/Learning (OHR) for the agency coordinates training and facilitates the many training and development activities offered through DBHDD. Some training initiatives are generated in response to gaps and challenges identified by various reviews and audits and others are developed as a result of quality improvement activities. All trainings are intended to improve the clinical skills of providers with whom the Department contracts for service delivery.

OHR has created DBHDD University and has implemented a Learning Management System (LMS) that provide online educational opportunities for both DBHDD staff and community providers. The LMS provides for course registration, record of course completions, assessment grades, transcripts, and printable course certificates. OHR facilitates many other training and development activities that are offered through DBHDD. Providers and system of care partners have received training in Trauma Informed Care, Transitions to Independence Process, Dialectical Behavior Therapy, Trauma-focused CBT, Crisis Planning and Safety Planning, Adolescent Co-Occurring Mental Health and Substance Use Disorders, Suicide Prevention of at-risk populations, Mental Health Training for Spoken Language Interpreters and Training for Mental Health Clinicians in Use of Spoken Language Interpreter Services, Cultural Competence and System of Care Leadership and Approaches. In addition, annually, OHR provides support to the Division of Behavioral Health for development and implementation of the Behavioral Health Provider Symposium. This symposium is held to present the latest innovations in service delivery, best practices, shared values, philosophies, expectations, and training related to the service system guidelines and policies. All providers are required to attend.

DBHDD also funds and sponsors an Annual Georgia System of Care Academy with the most recent one, System of Care Academy X, held in June 2017. The Annual System of Care Academy provides a shared value, principles, and practice focused conference. It is held each summer and key staff from DBHDD, Community Mental Health, Addictive Diseases, DFCS, GaDOE, DJJ, GVRA, DPH, DECAL, DCH programs, other professionals, families and youth from across the state are invited.

Emergency Services Worker Training

All services in the Georgia DBHDD system are provided under contract or agreement with private or public providers of behavioral health services. Local providers work with emergency personnel such as Sheriff's Departments, Hospital Emergency Rooms and county jails on issues related to individuals with behavioral health needs. The local providers educate these responders on the needs of individuals as well as on the services available through their agencies. In particular, in areas that are more rural, provider staff develops relationships with local hospital emergency rooms and other responders to keep them apprised of the unique needs of persons with mental illness and serious emotional disturbance in emergency situations. In the more metropolitan regions, the providers sometimes contract with outside vendors to do training of emergency personnel.

Behavioral Health Link provides information and marketing materials regarding the Georgia Crisis and Access Line to hospital emergency room personnel and local law enforcement staff. The intent is for all emergency services personnel to be informed of the availability and process for accessing 24/7 crisis response for any individuals in a crisis related to mental illness or addictive diseases.

DBHDD blends funds with the Georgia Public Safety Training Center (GPSTC), to provide CIT training to Georgia's law enforcement officers using a curriculum that blends best evidence based practices from the new Bureau of Justice Assistance (BJA) CIT Model,

the Memphis, Tennessee CIT model, and data gained from CIT practice in the field since 2006. In an effort to reduce the stigma associated with mental illness, the Georgia CIT Program's vision is a Georgia where citizens with serious mental illness receive medical treatment in lieu of incarceration. Georgia adopted a top-down approach to training law enforcement by forming a collaborative with executives from key departments of state government, mental health providers and advocacy organizations.

In response to requests from local law enforcement agencies wanting to increase their numbers of officers with at least some knowledge of behavioral health issues and response prior to their being able to attend the full week-long CIT course, NAMI facilitated a new DBHDD-funded Introduction to Behavioral Health Crisis curriculum--seven (7) 16-hour courses for Law Enforcement Officers waiting to attend the 40-hour CIT class, and eight (8) 8-hour courses for First Responders and 911 Operators— The goal and objective of the new training is to provide an in-service introductory course on behavioral health crisis for law enforcement officers as a precursor to the Georgia CIT Program.

In FY17, DBHDD's OCYF, entered a separate contract with NAMI Georgia, to provide CIT for Youth Training. In general, CIT for Youth programs train officers on adolescent brain development and how mental health symptoms manifest with youth. In addition, the training helps officers and school staff work to better address mental health concerns in a school setting. CIT for Youth programs teach law enforcement officers to connect youth with mental health needs to effective services and supports in their community. The goal is to intervene early in emerging mental health issues and prevent youth from becoming involved in the juvenile justice system. The programs work with schools, school-based police officers, children's mental health providers and parents to accomplish these goals.

During 2017, NAMI held several stakeholder meetings with over 175 stakeholders in Region 3 (Albany State University), Region 4 (Albany), and Region 5 (Savannah & Vidalia) to identify the barriers schools have connecting their students and resources available for them. Over 100 participants were trained on the CIT-Y, which included Atlanta Public Schools Police Department and Albany Police Department as well as a Train the Trainer training to the Atlanta Public School Department of Education.

The Georgia Bureau of Investigation (GBI) has incorporated a module on trauma into its monthly training for new Crisis Intervention Team (CIT) State Patrol officers across the state. The training includes interviews with actual individuals who have received services for PTSD, education on the signs and symptoms of trauma and other mental illnesses, as well as de-escalation techniques for use in working with persons in crisis related to trauma. A goal of the CIT training program is that officers understand that involvement in many infractions of the law may be a result of a person's trauma history or failure to receive proper trauma-informed treatment, rather than a result of intentional wrongdoing.

DBHDD's Assistant Director of Adult Mental Health Services is the Program Manager for the GPSTC contract and one of AMH's Behavioral Health Treatment Court Liaisons is a member of the GPSTC Crisis Intervention Team Training Advisory Board. DBHDD also has a Disaster Mental Health Coordinator's (DMHC) position which is fully funded by the Georgia Department of Public Health. DBHDD's DMHC works with the Georgia Emergency Management Agency and other emergency preparedness agencies to ensure that the behavioral health needs of Georgia residents are included in state-level plans. The DBHDD Regional Hospitals and provider agencies are members of Regional Emergency Preparedness Healthcare Coalitions throughout the state and they participate in exercises with local healthcare and emergency preparedness partners. Georgia's disaster mental health website at www.georgiadisaster.info contains information and resources on disaster mental health planning. DBHDD has a continuity of operations plan policy for its state office and policy that requires continuity of operations for all contracted providers. Disaster mental health training and exercises takes place throughout the state several times a year.

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Footnotes:

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2018-FFY 2019? Yes ☐ No

Please indicate areas of technical assistance needed related to this section.

None at this time.

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Footnotes:

During the SFYE 06/30/2019, DBHDD performed at least one quality review on >99% of behavioral health providers. Some of the areas considered in these comprehensive reviews include the following:

- Assessment & Treatment Planning
- Billing Validation
- Compliance with Service Guidelines
- Consumer Choice
- Person-Centeredness
- Whole Health
- Safety
- Consumer Rights
- Community Life

Aggregated data from these comprehensive reviews is used to identify and create training for providers, as well as inform Quality Improvement projects, suggest changes to policy, and ensure alignment of review activity with provider manuals.

Changes to the comprehensive quality review process have been implemented in SFYE 6/30/19, with an effective date of 7/1/2019. These changes are focused on increasing reliability and validity of data collected during the review process, as well as reducing provider burden.

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma[57] is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing ?business as usual.? These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[58] paper.

57 Definition of Trauma:*Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*
58 *Ibid*

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues? ☐ Yes ☐ No
2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers? ☐ Yes ☐ No
3. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care? ☐ Yes ☐ No
4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? ☐ Yes ☐ No
5. Does the state have any activities related to this section that you would like to highlight.

   DBHDD has a policy that requires all community providers to screen and assess for trauma and to connect individuals to appropriate treatment. Since FY16 DBHDD contracted providers have maintained implementation of a functional assessment tool, the Adult Needs and Strengths Assessment (ANSA). The ANSA and the child and adolescent version, the CANS, are multi- purpose tools developed for behavioral health services to support decision making, level of care and service planning, including the application of evidence-based practices, to facilitate quality improvement initiatives, and to allow for the monitoring of service outcomes. These tools require providers to assess the following trauma-related items:
   Adjustment to Trauma

- Sexual Abuse
- Physical Abuse
- Emotional Abuse
- Medical Trauma
- Natural/Manmade Disaster
- Witness/Victim to Family Violence
- Witness/Victim to Community Violence

Many of DBHDD's community providers serve foster children under agreements with the DCH/Division of Medicaid Care Management Organization contracts. The state child welfare agency, the Division of Family and Children's Services (DFCS), changed its policy in July 2012 related to trauma assessments. All youth coming into care must have trauma assessments.

DBHDD promotes use of evidence-based trauma-specific interventions across the lifespan through training. The DBHDD contracts with service providers require that provider staff receive appropriate in-service training. Training is provided through various statewide efforts including the annual Georgia School for Addiction Studies (GSAS) conference that offers the opportunity to increase provider capacity on a variety of behavioral health topics, including trauma-specific interventions. For example, the 2017 Eleventh Annual GSAS conference held August 28-September 1, 2017, included a trauma track and seven trauma-specific training offerings: Thief and Liar: Training Informed, Integrated Intervention; Shining Through the Wounds: Trauma-Informed Treatment and care; Overcoming Trauma with Tensegrity; Trauma, the Brain, and Co-Dependency; Healing Trauma Through Art; Domestic Violence and Substance Abuse: Understanding the Cycle; and Burnout and Secondary Trauma. In addition, the annual System of Care Academy and annual Behavioral Health Provider Symposium are designed to inform and train current Behavioral Health providers regarding best practices in the delivery of community mental health care.

Through the SAMHSA System of Care Expansion and Implementation grant, DBHDD in partnership with the Georgia State University Center of Excellence provides Trauma Informed Care training throughout the state. The training is targeted to all DBHDD behavioral health providers for child and adolescent services as well as other child-serving agencies. Staff from DBHDD and the Center received training to become trainers from the National Child Traumatic Stress Center.

Through the SAMHSA System of Care Expansion and Implementation grant, DBHDD in partnership with the Georgia State University Center of Excellence is providing Trauma Informed Care training throughout the state. The training is targeted to all DBHDD behavioral health providers for child and adolescent services as well as other child-serving agencies. Staff from DBHDD and the Center received training to become trainers from the National Child Traumatic Stress Center. In the previous two years, the Clinical Director of the Office of Children, Young Adults, and Families (OCYF) co-facilitated two-day trainings offered to every region in the state. In June of this year, in response to popular demand, the Clinical Director again co-facilitated trauma-informed systems training in two different regions of the state. As we are now considering sustainability plans, the Clinical Director will review and consider the trauma training protocol being implemented by our child welfare partners, to determine the feasibility of blending the two programs.

Trauma informed care has also been provided for the Office of Addictive Diseases" CABHI-COM funded Home for Recovery project. Staff have been trained in and are implementing the Trauma Recovery Empowerment Model (TREM) and TREM for Men by the project's two providers. The project provides recovery support for individuals 18 years of age and older who have been chronically homeless, are currently in permanent supportive housing and that have SUD, MH or co-occurring SUD and MH. The project includes a focus on serving veterans. Trauma informed trained project staff include Certified Peer Specialists (CPSs) and Georgia Certified Addiction Recovery Empowerment Specialists (CARES).

Each of Georgia's PATH Teams is required to hire a CPS with lived experience of homelessness, a circumstance that often results in exposure to trauma. Similarly, Georgia's 22 Forensic Peer Mentors, are CPS's with lived experience involving mental health and/or substance use history combined with past involvement with the criminal justice system, including incarceration, which often results in post-incarceration syndrome, triggered by living in an oppressive and often violent environment. CPS working in both of these roles are positioned to contribute to the development of trauma-informed organizations and the recovery of their peers currently in treatment. Additionally, CPS contribute their lived experiences while working in multiple arenas of the Adult Mental Health array of community services. There are peers who work on all 26 ACT teams, as well as on some community support teams, and on supported employment teams and throughout out crisis system; in behavioral health crisis centers, crisis stabilization units and mobile crisis response service. In FY 2019, the Office of Adult Mental Health provided a comprehensive trauma informed care training series for providers of these intensive community services.

Please indicate areas of technical assistance needed related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[59]

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.[60]
A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

[59] Journal of Research in Crime and Delinquency: : *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.*Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Ren?e L. Binder. **OJJDP Model Programs Guide**

[60] **http://csgjusticecenter.org/mental-health/**

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services? ☐ Yes ☐ No

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? ☐ Yes ☐ No

3. Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system? ☐ Yes ☐ No

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances? ☐ Yes ☐ No

5. Does the state have any activities related to this section that you would like to highlight?

   For individuals on probation or parole, the Department of Community Supervision (DCS) has established Specialized Mental Health Probation Officers, to provide more targeted supervision. DBHDD and the DCS are working collaboratively to develop a pilot to share resources in the community such that DBHDD can serve as consultant for these specialized officers and these officers may assist DBHDD as they work with mentally ill individuals in the community who may still pose a risk, but whose legal situations permit access to community behavioral health services.

   In SFY15 DBHDD signed a Memorandum of Agreement with GDC and DCS to further promote successful re-entry into the community for individuals with serious mental illness or co-occurring substance use disorders. DBHDD contracted with the Georgia Mental Health Consumer Network (GMHCN) to staff a pilot Forensic Peer Mentor Program. Certified Peer Specialists (CPS)s and/or Certified Addiction Recovery Empowerment Specialists (CARES, aka CPS-AD) were provided 40 hours of additional training to support individuals with behavioral health conditions to successfully transition from incarceration in prison to community living. Individuals identified by behavioral health clinical staff at program sites (state prisons, Day Reporting Centers (for probationers), and state hospital forensic units, who elected to participate, are paired with a Forensic Peer Mentor (FPM) who

offers assistance with self-direction in choice of housing, employment, service providers, etc. in transition planning, and in executing the plan to ensure connection with community services, employment and development of natural supports. The pilot program has evolved and been sustained and in FY17 21 Forensic Peer Mentors provided over 16,000 transition planning and support sessions to 246 Returning Citizens.

Additionally, DBHDD contracts with three community providers that employ FPMs to work in local Mental Health Treatment Courts. The FPMs are integral parts of the multidisciplinary treatment court team and vital support persons for individuals who have been diverted from incarceration and agreed to participate in treatment services.

In September 2016, then Governor Nathan Deal initiated additional training for law enforcement which included the CIT Program. The Georgia Public Safety Training Center (GPSTC), the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD), and the Georgia chapter of the National Alliance on Mental Illness (NAMI), partnered to expand Georgia CIT from the former DBHDD/NAMI collaboration for delivery of CIT to implementation of a more statewide expansion of the CIT Program, with the infusion of additional state dollars to the GPSTC budget (in addition to what DBHDD was already providing)

This expansion has increased the number of training opportunities law enforcement will receive regarding the various types of mental illnesses, addictive diseases, and other disorders including Autism and Alzheimer's disease. The GPSTC, DBHDD, NAMI, and other mental health advocates are collaborating to provide this training to law enforcement statewide. This collaboration speaks highly to the commitment these agencies have in serving and protecting all citizens of Georgia. It is the belief of these agencies, that joining efforts in this common cause will not only help those who may be in a mental health crisis, but to also provide the best service to the communities. The GPSTC and DBHDD's goal is to provide approximately 200 CIT classes statewide in a given year. This expansion will allow more law enforcement agencies and officers to have an opportunity to receive this critical training.

DBHDD is working with the Courts and GDC to ensure that individuals who are able to be diverted from, as well as individuals transitioning from, correctional institutions have access to Supportive Housing and the current array of behavioral health services. DBHDD continues to meet with the Courts and the Georgia Department of Corrections (GDC) to provide information about DBHDD's current array of evidence-based services, as well as how to access those services in a timely manner. In addition, organic local collaborations have occurred between local courts and community behavioral health providers.
In response to requests from local law enforcement agencies wanting to increase their numbers of officers with at least some knowledge of behavioral health issues and response prior to their being able to attend the full week-long CIT course, beginning in June of 2015, NAMI Georgia in collaboration with Georgia CIT Partners provided a new DBHDD-funded eight (8) hour class to law enforcement agencies that served as an introduction to mental illness and other behavioral health disorders for officers. The goal and objective of the new Introduction to Behavioral Health Crisis training is to provide an in-service introductory course on behavioral health crisis for law enforcement officers and first responders, including 911 Call Center dispatchers.
In addition, in FY17, DBHDD's OCYF, entered a separate contract with NAMI Georgia, to provide CIT- Youth Training. In general, CIT -Youth programs train officers on adolescent brain development and how mental health symptoms manifest with youth. The training helps officers and school staff work to better address mental health concerns in a school setting. CIT-Youth programs teach law enforcement officers to connect youth with mental health needs to effective services and supports in their community.

Please indicate areas of technical assistance needed related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

15. Crisis Services - Requested

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.[61] SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA's publication, **Practice Guidelines: Core Elements for Responding to Mental Health Crises**[62],

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response.

[61] http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848

[62] Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009 http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427

Please check those that are used in your state:

1. Crisis Prevention and Early Intervention
   - a) ☐ Wellness Recovery Action Plan (WRAP) Crisis Planning
   - b) ☐ Psychiatric Advance Directives
   - c) ☐ Family Engagement
   - d) ☐ Safety Planning
   - e) ☐ Peer-Operated Warm Lines
   - f) ☐ Peer-Run Crisis Respite Programs
   - g) ☐ Suicide Prevention
2. Crisis Intervention/Stabilization
   - a) ☐ Assessment/Triage (Living Room Model)
   - b) ☐ Open Dialogue
   - c) ☐ Crisis Residential/Respite
   - d) ☐ Crisis Intervention Team/Law Enforcement
   - e) ☐ Mobile Crisis Outreach
   - f) ☐ Collaboration with Hospital Emergency Departments and Urgent Care Systems
3. Post Crisis Intervention/Support
   - a) ☐ Peer Support/Peer Bridgers
   - b) ☐ Follow-up Outreach and Support
   - c) ☐ Family-to-Family Engagement
   - d) ☐ Connection to care coordination and follow-up clinical care for individuals in crisis
   - e) ☐ Follow-up crisis engagement with families and involved community members

f) ☐ Recovery community coaches/peer recovery coaches

g) ☐ Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

DBHDD has a live referral board and census for the crisis system. While some states run a bed registry, very few have a live census and can determine the number of individuals waiting for care and the live bed availability across the system. The referral board is in the process of an update, funded in part by a TTI grant through NASMHPD, that will allow portal access by emergency rooms to not only post a referral, but to communicate electronically with the receiving facility instead of waiting for an arranged time for a telephone consultation. The live referral board allows for quicker access to the right level of care for individuals waiting for treatment as well as provides essential data that helps Georgia forecast and improve the crisis system.

DBHDD contracts for provision of a comprehensive crisis system that includes statewide mobile crisis response, and community-based crisis stabilization units and walk-in adult behavioral health crisis centers. These services are effective in responding to individuals in crisis via provision of de-escalation, , assessment and triage, stabilization and linkage to appropriate after-care services. DBHDD has recognized the increased need for Peer services in the Crisis System. Persons with lived experience are being added to the Behavioral Health Crisis centers and all units have been trained on a peer first- peer last model of engagement. DBHDD contracts for provision of services that support prevention and postvention of crises, including peer wellness and respite centers and crisis respite apartments. Peer wellness and respite centers are peer-run and allow individuals access to necessary non -crisis peer supports as a component of their ongoing recovery. Crisis respite apartments provide a short-term supportive community residential setting that facilitates transition back into the community following a crisis such as hospital, CSU or BHCC admission.

Please indicate areas of technical assistance needed related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

16. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life to the greatest extent possible, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? ☐ Yes No

b) Required peer accreditation or certification? ☐ Yes No

c) Block grant funding of recovery support services. ☐ Yes No

d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system? ☐ Yes No

2. Does the state measure the impact of your consumer and recovery community outreach activity? Yes ☐ No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

Recovery for adults living with a SMI will be different for each person, depending upon their goals, strengths, supports, interests, and available community resources. Some use medication, while others rely on peer support and illness self-management and wellness skills. Some may continue to experience symptoms; others may not. The important thing is that individuals are leading meaningful lives, engaged with the community and natural supports.

DBHDD offers a variety of recovery support services, including connection to affordable housing, vocational rehabilitation and supported employment services. Certified Peer Specialists (CPSs) are the foundation of DBHDD's recovery supports. CPSs with specialized training offer Peer Mentoring to individuals transitioning from hospitals or prisons. Peer Support Programs and Individual Peer Support Services are available in the formal service system to promote self-directed recovery and help individuals explore personal meaning, tap into strengths, establish natural support systems, and work toward achievement of life and recovery goals. Whole Health & Wellness Peer Support services are offered to individuals who wish to work on overall health goals (i.e. depression and diabetes management). Training in the development and use of Wellness Recovery Action Plans is also available to individuals within and outside of the formal treatment system.

Outside the traditional system of care, DBHDD contracts with the Georgia Mental Health Consumer Network (GMHCN) to operate the Georgia Certified Peer Specialist training & certification program; provide education on self-directed recovery, tools and skills; and provide community-based peer support groups and drop-in centers. Each August over 500 individuals attend the 3- day statewide MH consumer conference. Twice a year, the Georgia Peer Support Institute offers, to a smaller group, a 3-day immersion in the hope of recovery and self-direction. Wellness Recovery Action Plan (WRAP) training is available to peers across the state, in and outside of traditional service settings. Double Trouble in Recovery peer support groups are offered across the state to individuals with co-occurring mental and substance use disorders.

Telephonic Peer Support is available 24/7/365; and daily wellness activities are offered on a drop-in basis, at the five consumer-operated Peer Support, Wellness & Respite Centers (PSWRCs). The PSWRCs also offer peer respite services as an alternative to psychiatric hospitalization.

Recovery for children with SED and their families means that the children and families are empowered with the knowledge, skills, resources and supports to function within their home, school, and community, and the youth are able to achieve developmentally appropriate milestones and self-determined goals toward adulthood. While DBHDD has been supporting the organization of Federation of Families chapters across the state, and conducting the Youth Leadership Academy to empower parent and youth advocacy and leadership, the most comprehensive recovery support is the cultivation of a certified peer workforce for parents and youth. Certified Peer Specialist-Parents (CPS-Ps) have been trained to use their experience raising a child with BH/SED to encourage, engage and empower parents by enhancing community living skills, developing natural supports, navigating the system of care, and using interventions that support the youth's natural environment. Certified Peer Specialist-Youth (CPS-Y) have been trained to use their experience of being in recovery from a childhood BH/SED condition to help encourage, engage and empower the youth to understand differing views and more effectively communicate their needs and desires to parents and members of the system of care; as well as how to engage with friends and supporters at school and in the community. Cultivation of the parent and youth peer support services has led to an increase in parent and youth leadership, advocacy and involvement in the system of care, as well as the growth of 28 Federation of Families chapters and 3 Youth Move organizations.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

Recovery from substance use disorders will vary, depending upon the path individuals choose. Some want complete abstinence; others may opt for medication-assisted treatment for detoxification, on-going maintenance, and/or to manage the symptoms of a co-occurring mental disorder.

While DBHDD offers Recovery Residences to help recovering individuals get back on their feet after treatment, the foundation of recovery supports is the CPS-AD, who are trained to use their lived experience with a substance use disorder to provide peer support to those seeking to maintain their recovery. In the formal treatment system, CPA-AD's run AD Peer Support Programs and provide Individual Peer Support services which promote recovery, advocacy, relationship enhancement, self-awareness, values and self-directed care. Recovery Support Centers provide hope, healing and wellness in a safe and comfortable environment, and utilize peer support to help individuals who drop-in, work on their life goals and connect to vocational, educational, employment, transportation, case management, family support, life skills and other types of resources.

SAMHSA's Opioid Crisis grant is allowing Georgia to expand the reach of peer support by funding a 24/7/365 peer support warm

line for individuals seeking treatment or recovery services ; requiring providers of expanded Medication Assisted Treatment to employ CPS-AD's to support individuals in exploring other pathways to recovery; implementing two peer support programs in emergency rooms to engage with individuals treated for opioid or other drug abuse and connect them to treatment and recovery resources. The presence of CPS-AD's in Georgia's treatment system and communities is strengthening the voice of the recovery community at state and local levels; supporting DBHDD in Recovery Community development; advancing the hope and understanding of recovery, and ensuring that recovery supports and services are available and accessible to all who need and want them.

5. Does the state have any activities that it would like to highlight?

DBHDD has been working with Joel Slack for a number of years to develop the Respect Institute of Georgia. This initiative emphasizes the power of being treated with dignity and respect, and teaches adults to tell their recovery story to various audiences. Over the past 2 years DBHDD has created a RESPECT Institute specifically designed for youth and young adults. This program provides 8 -10 youth and young adults ages 16-27, with the skills and coaching necessary to transform their personal and family stories, behavioral health service experiences, and recovery journey into educational and inspirational presentations of varying amounts of time, for diverse audiences. The Youth RESPECT Institute graduation is strategically scheduled to coincide with the Parent & Youth CPS training and technical assistance events. This training day combines youth recovery stories with an orientation of the emerging Medicaid service for Parent & Youth Peer Support. DBHDD Child and Adolescent Providers receive a preview of the service including understanding the competencies, service definition, billable codes, and notes. Providers can also expect to learn about:

- Preparing organizational culture, patterns, habits, and structures to contribute to the successful inclusion of peer support partners:
- Identifying potential candidates to apply for the Parent/Youth CPS training;
- Developing effective partnerships between peer and professionals;
- Receive highlights from Georgia's new curricula for Parent and Youth Peer Specialist Certifications;
- Understanding the unique roles of the Certified Peer Specialist-Parent (CPS-P) and Certified Peer Specialist – Youth (CPS-Y).

In September 2016, the DBHDD and its Office of Addictive Diseases was awarded a second three-year SAMHSA Cooperative Agreement to Benefit Homeless Individuals (CABHI) grant. CABHI is jointly funded by the Center for Substance Abuse Treatment and the Center for Mental Health Services. The purpose of the DBHDD Home for Recovery CABHI project is to increase capacity in Georgia to provide accessible, effective, comprehensive, coordinated/integrated, and evidence-based recovery support services and peer supports and peer navigator services and other critical services to persons who are experiencing chronic homelessness with substance use disorders, severe mental illness or co-occurring substance use and mental disorders and who are in Shelter Plus Care or in other permanent housing slots. Project services are implemented by two of DBHDD Tier Comprehensive Community Providers, Cobb Douglas Community Service Board and Highland Rivers Health. Project participants, who are chronically homeless and have a substance use disorder, severe mental illness and/or co-occurring mental illness and substance us, receive recovery-oriented services including certified peer specialist services. The project uses the Trauma Recovery Empowerment Model (TREM) as one of its evidence-based practices.

In April 2017, DBHDD was awarded a State Targeted Response to the Opioid Crisis Grant by the Substance Abuse and Mental Health Service Administration (SAMHSA). The funding, totaling nearly $11.8 million, is provided for in the 21st Century Cures Act of 2016, and will support DBHDD and other community providers combatting opioid addiction through prevention, treatment, and recovery services. Recovery activities include implementation of peer specialist programs in two hospital emergency departments; incorporating certified peer specialists in identified emergency departments to ensure immediate connection for individuals who have experienced an opioid overdose or individuals with an opioid use disorder who are presenting for services; establishing funding to support the infrastructure of recovery transitional housing; expanding/developing recovery support services for individuals with opioid use disorder; and implementing a warm line, run by peers, for individuals struggling with opioid use disorder.

The annual Georgia School of Addiction Studies (GSAS) offers a unique opportunity for professional development, information exchange, and networking. It is designed to address the need for knowledge and skill development through advanced training. The purpose of the GSAS is to: 1) foster and maintain the integrity of substance abuse related services by assisting in providing continuing training and education programs for more than 500 human service providers each year whose duties include prevention, intervention, treatment, law enforcement, child welfare, victim's services, law enforcement, court system, education, and rehabilitation or related social services; 2) to promote a broader understanding of, response to, and acceptance of, the process of addiction and its impact in areas of health, family, community, crime and the workplace; and 3) to encourage the exchange of professional knowledge through educational conferences and programs of continuing.

Six DBHDD Office of Addictive Disease staff and two members of the Office of Behavioral Health Prevention staff serve on the Georgia School of Addiction Studies Board and help plan the conference program agenda. The five-day annual conference includes prevention, treatment and recovery presentations and workshops. The 11th Annual Conference, held August 28 through September 1, 2017 includes the following training events: Finding Hope in the Darkest Places; From the Darkness of Columbine and Addiction to the Light of Recovery (presented by Columbine survivor); Words Matter – Let's Talk About Recovery; Youth in Peer Leadership and Small Group Setting; Ready, Set – Change! Navigating Life During the Recovery Process; Recovery Ready Ecosystems – Bridging Prevention, Treatment, and Recovery; and Families in Crisis – Working with Families in Recovery.

Please indicate areas of technical assistance needed related to this section.

We are in the exploratory stages of developing an add-on certification of Older Adult Peers. We would be open to any TA in this area.

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Footnotes:

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in **Olmstead v. L.C., 527 U.S. 581 (1999)**, provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights **(OCR)** cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

Please respond to the following items

1. Does the state's Olmstead plan include :

Housing services provided.	☐ Yes	No
Home and community based services.	☐ Yes	No
Peer support services.	☐ Yes	No
Employment services.	☐ Yes	No

2. Does the state have a plan to transition individuals from hospital to community settings? ☐ Yes No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

DBHDD is actively engaged in a wide range of activities to address community integration as a result of the Department of Justice v. Georgia Settlement Agreement and subsequent Settlement Agreement Extension. Since October 2010, DBHDD has expanded the availability of adult community based services for individuals with mental illness to include 22 Assertive Community Treatment (ACT) Teams, 10 Community Support Teams (CST), 14 Intensive Case Management (ICM) Teams, and 52 Case Managers (CM), a peer supports program that serves more than 835 individuals annually, 6 Behavioral Health Crisis Centers, a statewide Crisis and Access Line that is accessible 24/7, 24 Crisis Respite Apartments, and a supported employment program serving more than 2,000 individuals in FY19. DBHDD's contracted ACT teams provide services and supports to approximately 2,500 persons with a serious and persistent mental illness categorization annually. Individuals enrolled in ACT or CST services maintain a housed/non-homeless average of 95%. Additionally, DBHDD's contracted providers of Supported Employment assist persons in exploring vocational opportunities and obtaining jobs, while maintaining a competitive employment rate of 49% for enrolled individuals.

To promote housing availability, DBHDD contracts for the operation of more than 1,900 Community Residential Rehabilitation units and has provided access to supported housing to more than 4,000 persons with a serious and persistent mental illness through the DBHDD funded Georgia Housing Voucher Program.

The Georgia Department of Behavioral Health (DBHDD) and Georgia Department of Community (DCA) affairs signed an intergovernmental Memorandum of Agreement in 2015 to expand the provision of independent supported housing and support community integration for those meeting the settlement agreement criteria. A Unified Referral (UR) process was created to streamline housing referrals directly from DBHDD state hospitals, crisis centers, community-based outpatient services and other access points, allowing eligible individuals to be considered for multiple rental assistance programs. DCA updates DBHDD and its

providers on any new housing resources that become available on a regular basis. Georgia was awarded $14.4 Million from HUD to provide long term project based rental assistance to person with disabilities who are a part of the DOJ settlement agreement. Housing units are attached to new and existing tax credit apartment developments around the state (this is not he portable voucher system). Georgia was given a HUD Housing Choice Preference (formerly known as Section 8) for individuals who meet eligibility under the DOJ settlement agreement.

Some of these housing resources, such as HUD 811 vacancies, are provided on an ongoing basis as they become available. Through the Unified Referral Process (URP) potential housing options for individuals are identified by DCA on a weekly basis and communicated to DBHDD regional staff and providers. Other resources are presented as they become available on a cyclical basis, such as Emergency Solutions Grants (ESG), Housing Opportunities for Persons with AIDS (HOPWA), HUD Continuum of Care (including Shelter Plus Care and Coordinated Entry), and the Reentry Partnership Housing Program (RPH), that have annual or bi-annual application cycles for funding.

Some recent and ongoing ways these housing updates have occurred include:

- DCA weekly staffing meetings of individuals that come through the URP system. The HUD 811 Coordinator at DCA conducts a weekly staffing of all referrals from DBHDD providers utilizing URP. These staffing meetings include a variety of DCA OHSN staff that work directly with HUD 811, ESG, HOPWA, Continuum of Care (CoC), Shelter Plus Care (S+C), and RPH. For homeless individuals, referrals are made to the Coordinated Entry systems in their communities. In addition to the programs, referrals are also made, as appropriate, to housing programs for veterans like Supportive Services for Veteran Families (SSVF) and VASH, domestic violence housing providers and shelters, and for Settlement eligible preference Housing Choice Vouchers (HCV).
- The HUD 811 Coordinator sends weekly updates to DBHDD staff, Regional Coordinators and providers listing all vacancies available in the program, the property locations, and the timeframe in which they need to be filled.
- DCA participates in monthly conference calls with DBHDD staff and their Regional Coordinators. During these calls information regarding HUD 811 vacancies is reiterated, and any questions the Regional Coordinators may have about specific properties or processes are answered.
- On April 9, 2018 DCA conducted a webinar covering the RPH program and providing information on how they can become RPH approved housing providers targeted individuals leaving a state prison with a mental health illness. The presentation was made available to all DBHDD Community Service Board (CSB) executives. 20 CSB executives attended the webinar. Several CSBs attended subsequent RPH application workshops. The RPH program has a bi-annual application process for potential housing providers, and the spring cycle will close on May 30, 2018.
- Many DBHDD providers, such as CSBs and agencies with PATH teams, also receive HUD funding for housing through DCA. Many DBHDD providers are currently recipients of ESG and S+C funding in particular. These HUD funded housing grants are awarded on an annual basis. In March 2018, DCA conducted four ESG/HOPWA/S+C Supportive Services application workshops throughout the state (Macon, Moultrie, Chamblee, Augusta), in addition to one webinar. In April 2018, three follow-up Q&A webinars were conducted related to the ESG/HOPWA/S+C Supportive Services applications. DBHDD providers were invited to attend all of these workshops and sessions and were encouraged to apply for funding.
- The Re-entry Housing Program has conducted workshops related to its spring funding cycle in April 2018. In addition to a webinar, three in-person application workshops were held, in conjunction with the Department of Community Supervision (DCS), in Macon, Augusta, and Gainesville. At least several DBHDD providers attended these workshops, and many others were notified and encouraged to apply.
- DCA has agreed to waive the normal one year waiting period for HCV preference vouchers that are ported to PHAs that may be more appropriate geographical locations for eligible individuals or families. Anyone who is eligible for an HCV preference voucher due to Settlement eligibility is immediately able to port to another PHA without waiting.
- The Atlanta Housing Authority (AHA) has agreed to convert GHVP vouchers for individuals whose leases are expiring under that program to HCV vouchers. This transition is made entirely within the AHA's jurisdiction, outside of DCA's Settlement eligible preference, and is an example of how DCA has been able to work with another PHA to expand HCV opportunities to the Settlement eligible population.
- DCA has conducted a 6-month series (2019) of Supported Housing workshops including Access to Federal Housing Programs, Fair Housing, Reasonable Accommodation, Landlord/Tenant Law, Olmstead, Quality Housing Inspections.

DBHDD provides transition planning from the day of admission. Significant policy revision and training have occurred to promote improved hospital to community transition. An individual's own recovery goals are considered when developing the plan of care and assisting with the linkage to community-based services after transition into the community. Once a community service provider is identified, and a release of information from the individual, providers are strongly encouraged to actively engage in the transitioning and discharge planning process. The hospital is recovery focused and utilizes the "Individualized Recovery Plan" to guide an individual's treatment and recovery.

Individuals who have taken longer to stabilize (more than 45 days) or who have been readmitted within 30 days of discharge or 3 times in 12 months receive an additional level of transition planning in order to support the individuals' successful transition into the community. DBHDD is able to offer those transitioning from hospitals into community settings a continuum of housing options based on need. Housing options range from supervised residential settings to supported independent apartments based on housing first principals.

Our Assertive Community Treatment (ACT) teams provide services and supports to approximately 1500 persons annually, who have a serious and persistent mental illness categorization. ACT along with CST which support on average 350 persons annually who

have a serious and persistent mental illness categorization maintain a housed/non-homeless average percentage of 95% for persons enrolled in these services. DBHDDs contracted providers of Supported Employment assist 2000 persons in exploring vocational opportunities and obtaining jobs and maintain a competitive employment rate for enrolled individuals of 49%.

Please indicate areas of technical assistance needed related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[63]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[64]. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.[65].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[66]. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[67].

According to data from the 2015 Report to Congress[68] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

[63]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[64]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[65]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[66]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[67]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from**https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

[68] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery and resilience of children and youth with SED? ☐ Yes ☐ No

b) The recovery and resilience of children and youth with SUD? ☐ Yes ☐ No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare? ☐ Yes ☐ No

b) Juvenile justice? ☐ Yes ☐ No

c) Education? ☐ Yes ☐ No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? ☐ Yes ☐ No

b) Costs? ☐ Yes ☐ No

c) Outcomes for children and youth services? ☐ Yes ☐ No

4. Does the state provide training in evidence-based:

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? ☐ Yes ☐ No

b) Mental health treatment and recovery services for children/adolescents and their families? ☐ Yes ☐ No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? ☐ Yes ☐ No

b) for youth in foster care? ☐ Yes ☐ No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

System of Care (SOC) is an organizational framework for how behavioral health services and supports delivery systems can work together to fit the needs of the community, county, region, or state. The SOC framework is based on core principles and values: community based, child-centered and family focused (involving youth and family as partners), culturally and linguistically competent, comprehensive, individualized, and provided in the least restrictive, most integrated and most appropriate setting as possible.

Starting in 1984, Georgia began utilizing several SAMHSA and CMS grant initiatives to build a strong, statewide SOC: Child and Adolescent Service System Program recipient; Child and Adolescent State Infrastructure; Substance Abuse Coordination; Healthy Transitions Initiative; CMS Alternatives to Psychiatric Residential Treatment Waiver Demonstration Grant; CHIPRA Quality Improvement; Project LAUNCH; Project AWARE; and the Cooperative Agreement for Expansion and Sustainability of the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances (SEDs) Grant (Systems of Care Expansion Grant).

Georgia's system is designed with local, regional, and state-level SOC infrastructures that complement and support each other. Local Interagency Planning Teams (LIPTs), required by Georgia Code § 49-5-225, were established at the local level to improve and coordinate services for children and youth with SEDs. The main charge of LIPTs are to bring planning and resources to support

youth with remaining in their communities, homes, and schools. There are 119 LIPTs covering all 159 counties located across the state that meet as needed to coordinate services and supports for youth and families. Systemic issues identified by LIPTs are passed along to the Interagency Directors Team (IDT).

Per Georgia Code § 37-2-4, Georgia's Behavioral Health Coordinating Council (BHCC) was created in 2010 to "identify overlapping services regarding funding and policy issues in the behavioral health system." The BHCC is a commissioner-level council that supports behavioral health services throughout the state. The BHCC is chaired by the Department of Behavioral Health & Developmental Disabilities (DBHDD) Commissioner, and members include commissioner and division director-level representatives from each state agency that is impacted by behavioral health, as well as members of the Georgia legislature, and family and consumer representatives. The BHCC meets quarterly, and the chair provides regular updates to the Governor.

In 2011, DBHDD formalized the IDT as a working group of the BHCC. The IDT is the state's multiagency SOC leadership collaborative, whose mission is to manage, design, facilitate, and implement the SOC in Georgia. The IDT meets monthly. Membership, which is composed of director-level representatives from all child-serving agencies in Georgia and other partner organizations. Agency membership includes: Behavioral Health & Developmental Disabilities; Community Health (Medicaid Authority); Early Care & Learning; Education; Family & Children Services; Juvenile Justice; Public Health; and Vocational Rehabilitation Agency. Remaining members include: Care Management Entities (Lookout Mountain CME, View Point Health CME); The Carter Center; Children's Healthcare of Atlanta; Georgia Appleseed; Georgia Early Education Alliance for Ready Students; Georgia Parent Support Network; Georgia State University (Center of Excellence for Children's Behavioral Health; Center for Leadership in Disability); managed care organizations (Amerigroup; CareSource; PeachState; WellCare); Mental Health America of Georgia; National Alliance on Mental Illness; Resilient Georgia; professional associations (Georgia Alliance of Therapeutic Services for Children & Families; Georgia Association of Community Service Boards; Georgia Chapter, American Academy of Pediatrics; Together Georgia; United Way of Greater Atlanta; and Voices for Georgia's Children. The Centers for Disease Control and Prevention is a consulting partner.

7. Does the state have any activities related to this section that you would like to highlight?

Georgia has utilized several SAMHSA and CMS grant initiatives to build a strong, statewide SOC. Further, Georgia has sustained programs, supports, and momentum with state funds after our SAMHSA grant periods have ended. For example, the Center of Excellence for Children's Behavioral Health (COE) was created in partnership with Department of Behavioral Health & Developmental Disabilities (DBHDD). Modeled after the Institute for Innovation at the University of Maryland, a national leader in children's behavioral health services, the COE is housed in the Georgia Health Policy Center, in the Andrew Young School of Policy Studies at Georgia State University. Initially the COE was created to provide technical assistance, monitor, and evaluate, High Fidelity Wraparound (HFW) supporting children with Severe Emotional Disorders, and for the first three years, was funded with federal funds saved through the PRTF demonstration grant. Realizing the value of the COE, DBHDD has sustained the center with state dollars and the responsibilities of the COE have continued to grow. The COE provides support in a number of ways, most notably through training and technical assistance, fidelity monitoring, research and evaluation, and policy and finance publications. Additionally, the COE provides backbone support for the Interagency Directors Team, and for the Georgia System of Care.

Please indicate areas of technical assistance needed related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years? ☐ Yes ☐ No

2. Describe activities intended to reduce incidents of suicide in your state.

   DBHDD continues to implement a multifaceted approach to reduce incidence of suicide in Georgia. Among these efforts, is the application of the Zero Suicide approach supported by DBHDD Policy 01-118, Suicide Prevention, Screening, Brief Intervention and Monitoring. The Zero Suicide framework is a system-wide, organizational commitment to safer suicide care in health and behavioral health care systems – Georgia has been working with experts to apply this framework to college and university campuses. The framework is based on the realization that suicidal individuals often fall through the cracks in a sometimes fragmented and distracted health care system. A systematic approach to quality improvement in these settings is both available and necessary. To date, there have been three Zero Suicide Academies completed and more than two dozen college and university personnel trained in this approach.

   This policy can be found at this link: https://gadbhdd.policystat.com/policy/5998394/latest/

   Additionally, the Georgia DBHDD has implemented evidence-based suicide screening, assessment, and safety planning trainings for clinicians with responsibility for suicide screening and care.

3. Have you incorporated any strategies supportive of Zero Suicide? ☐ Yes ☐ No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? ☐ Yes ☐ No

5. Have you begun any targeted or statewide initiatives since the FFY 2018-FFY 2019 plan was submitted? ☐ Yes ☐ No

   If so, please describe the population targeted.

   First, the Georgia DBHDD has implemented a statewide training initiative to support clinicians and suicide gatekeepers. It's called the Mental Health Awareness Training (MHAT) Project. The goal of the Mental Health Awareness Training (MHAT) Project is to help Georgia communities to reduce risks that may contribute to suicide attempts and/or death by suicide.

   Objectives include the following:
   1. Provide at least 20 evidence-based mental health awareness trainings across the state annually, targeting counties in DBHDD regions 1, 2, 3, 5, and 6 that were identified in 2015 as having the highest rates of suicide deaths in Georgia.
   2. Refer at-risk and vulnerable populations to participating community service boards (DBHDD's safety-net providers).
   3. Train at least 600 individuals (average 200 per year) by the end of the three-year project in evidence-based trainings, such as Question-Persuade-Refer, adult and youth Mental Health First Aid, Assessing and Monitoring Suicide Risk, Applied Suicide Intervention Skills Training, and SuicideTALK. This objective includes training 50 trainers to help sustain mental health awareness training capacity after the grant ends.

   Individuals targeted for MHAT will include those who can provide support to veterans, youth, and older adults. Training participants will include behavioral health professionals, nurses, teachers, clergymen, community suicide prevention coalition members, caregivers, corrections staff, first responders, youth workers, school support staff, and veterans and family members of armed service members.
   Overall, Georgia DBHDD focuses its efforts on people at risk of suicide, serious mental illness (SMI), and geographically – communities with high burdens of suicide deaths.

   Garrett Lee Smith (GLS) Georgia Suicide Safer Communities for Youth Project
   As a part of larger funding issued to The Georgia Department of Behavioral Health and Developmental Disabilities' (DBHDD)

through the Garrett Lee Smith federal funding from September 2015 through September 2020, The College and University Coalition, made up of over 30 institutions of higher education including technical schools and public and private colleges and universities, is included in the Georgia Suicide Safer Communities for Youth Project.

Under this project, The Georgia College and University Suicide Prevention Coalition will provide a yearly Suicide Prevention Conference for Colleges and Universities, three additional suicide prevention training opportunities a year and assessment, data collection, tracking and evaluation services for the College Coalition. The Georgia College Suicide Prevention Coalition (College Coalition) will oversee targeted college and post-secondary education efforts. The efforts of Georgia's colleges and universities are included in the GLS goals to serve 5,000 youth and their families over the life of the 5-year project.

Strategic Prevention Framework (SPF) for Suicide Prevention
The Georgia Department of Behavioral Health and Developmental Disabilities, Office of Behavioral Health Prevention has demonstrated success as a leading authority on combating suicide risk through its statewide, regional, and local partnerships. Further, the success of its Garrett Lee Smith youth suicide federal grant continues to build prevention capacity for youth service providers, colleges/universities, etc.

Georgia's suicide rates have typically been under the national average over the last 10 years, while the South's rates are over the national average. In 2016, suicide deaths and rates were highest for ages 50-54, followed by ages 20-24. In the 80-84 age group, the suicide rate peaks, but the number of deaths is not as high in older age. While there is no one single cause for a death by suicide, there are opportunities using evidence-based approaches to greatly reduce suicide risk-taking for youth, adults, and vulnerable populations which DBHDD is uniquely qualified to lead in Georgia.

The overall focus on prevention is done through a widely accepted, evidence-based Strategic Prevention Framework (SPF) that has been successfully used in Georgia substance abuse prevention programs. The five steps include: 1. Assessment, 2. Capacity, 3. Planning, 4. Implementation and 5. Evaluation as part of an intensive capacity-building approach to addressing a set of data driven priorities at the community level. Communities will be selected through a separate process to participate in the Strategic Prevention Framework for Suicide Prevention. SPF Suicide Prevention communities will be in selected high burden counties in Georgia based on 1) death by suicide rates county data; 2) And an existing capacity to address suicide in context of Opioids and substance addiction.

In February 2019, the Georgia DBHDD updated and expanded DBHDD Policy 01-118 Suicide Prevention, Screening, Brief Intervention, and Monitoring. DBHDD has specifically targeted consumers at-risk for suicide in its Tier 1 and Tier 2 and 2+ provider organizations. The revised policy provides standards for evidence-based suicide screening clinical trainings, system-wide screening protocols, and a companion document to support clinical responses.

Please indicate areas of technical assistance needed related to this section.

None at this time.

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Footnotes:

1. The state of Georgia has not updated the suicide prevention plan in the last two years. Georgia has taken initial steps to update the existing plan by convening a diverse, cross-section of suicide prevention and mental health stakeholders for a consultation meeting in March 2019. The consultation meeting resulted in several committees being formed to prioritize suicide prevention goals. Suicide prevention goals and objectives are being drafted for review by December 2019. The final version of the 2020-2025 plan is expected to be finalized by spring 2020.

3. After researching successful approaches to suicide reduction, the Georgia DBHDD under its Garrett Lee Smith Youth Suicide Project has identified seven essential elements of suicide care for college and university systems to adopt:
(1) Lead system-wide culture change committed to reducing suicides
(2) Train a competent, confident, and caring workforce
(3) Identify individuals with suicide risk via comprehensive screening and assessment
(4) Engage all individuals at-risk of suicide using a suicide care management plan
(5) Treat suicidal thoughts and behaviors using evidence-based treatments
(6) Transition individuals through care with warm hand-offs and supportive contacts
(7) Improve policies and procedures through continuous quality improvement

4. The Zero Suicide Academy is one specific initiative to focus on improving care transitions for suicidal individuals known to college personnel, returning after care from local clinics and hospitals.
Additionally, GA DBHDD has provided specific training and protocol development support for social workers and medical providers at Children's Hospital of Atlanta (CHOA), and Grady Memorial Hospital in Atlanta in beginning in 2019.

Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD conditions and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? ☐ Yes ☐ No

2. Has your state identified the need to develop new partnerships that you did not have in place? ☐ Yes ☐ No

   If yes, with whom?

   Center for START Services
   RI International
   Georgia Public Safety Training Center
   City of Atlanta Continuum of Care
   University of Georgia School of Social Work
   Children's Healthcare of Atlanta
   Georgia Appleseed
   DeKalb Criminal Justice Treatment Coalition

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilites Education Act.

   DBHDD has developed partnerships with agencies that serve and support people with addictive diseases, adults with Serious and Persistent Mental Illness, and Children and Adolescents with Serious Emotional Disturbances and their families. These agencies include the Department of Community Health, Division of Medicaid Assistance; the Department of Corrections; the Department of Community Supervision, Department of Public Health; the Georgia Vocational Rehabilitation Agency; the Department of Community Affairs, Housing Division; the Department of Education; the Department of Public Health; the Department of Human Services, Division of Aging Services DBHDD leads or participates in Councils with multiple agency representatives that address the needs of our target population to include the DBHDD Behavioral Health Coordinating Council, Georgia Interagency Council on

Homelessness, and the State Behavioral Health Planning and Advisory Council, the Fulton County Justice and Mental Health Task Force, Metro Atlanta Reentry Coalition, Council of Accountability Court Judges, Criminal Justice Coordinating Council, Macon Public Offenders Office and Sheriffs Council. In addition, Behavioral Health staff serve on advisory and governing bodies. Through these advisory and governing bodies, DBHDD coordinates and collaborates to plan for and implement services and supports needed by behavioral health consumers. In addition, DBHDD has developed agreements with other state agencies to either provide or collaborate on obtaining needed services and supports. The State Behavioral Health Planning and Advisory Council (BHPAC) includes representatives from various state agencies.

In 2011, DBHDD formalized the Interagency Director's Team (IDT) as a working group of the Behavioral Health Coordinating Council (BHCC). The IDT is the state's multiagency SOC leadership collaborative, whose mission is to manage, design, facilitate, and implement the SOC in Georgia. The IDT continues to meet monthly. Membership is composed of director-level representatives from all child-serving agencies in Georgia and other partner organizations. Agency membership includes: Behavioral Health & Developmental Disabilities; Community Health (Medicaid Authority); Early Care & Learning; Education; Family & Children Services; Juvenile Justice; Public Health; and Vocational Rehabilitation Agency. Remaining members include: Care Management Entities (Lookout Mountain CME, View Point Health CME); The Carter Center; Children's Healthcare of Atlanta; Georgia Appleseed; Georgia Early Education Alliance for Ready Students; Georgia Parent Support Network; Georgia State University (Center of Excellence for Children's Behavioral Health; Center for Leadership in Disability); managed care organizations (Amerigroup; CareSource; PeachState; WellCare); Mental Health America of Georgia; National Alliance on Mental Illness; Resilient Georgia; professional associations (Georgia Alliance of Therapeutic Services for Children & Families; Georgia Association of Community Service Boards; Georgia Chapter, American Academy of Pediatrics; Together Georgia); United Way of Greater Atlanta; and Voices for Georgia's Children. The Centers for Disease Control and Prevention is a consulting partner.

Please indicate areas of technical assistance needed related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC).SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration**[69].

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

[69] https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council involved in the development and review of the state plan and report? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.

   a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

   Planning for Behavioral Health services, including substance abuse treatment services, services, begins at the local level, initiated by the Field Offices in the six regions of DBHDD. Each Field Office works with their providers and key stakeholders to identify needs in their region. A primary mechanism for this is through Regional Community Collaboratives. In addition, there are Regional Advisory Councils (RACs) which include consumers and family members that provide recommendations to the regions and DBHDD. The Chairs of these RACS form a State Leadership Council and this Council has membership on the GBHPAC. The process incorporates input from individuals receiving services, families, advocates, community and hospital providers, and other local stakeholders. The process informs the delivery of behavioral health services in Georgia. The Field Office process is guided by the consumer-oriented, community-based values and principles of DBHDD. Field Offices:

   • Actively seek input from local stakeholders through public forums, written surveys, public comment at meetings, and individual input from consumers and families;
   • Ensure regional priorities, based on the local needs of consumers, families, advocates, providers and other stakeholders, are communicated;
   • Ensure the consideration of prevalence data and population demographics;
   • Inform local stakeholders of the regional priorities and needs;
   • Ensure the development of priorities focused on the entire regional system of care including community programs and state hospitals;
   • Provide input for the development of overall state plans for services; and
   • Inform the Department's annual budgetary process.

   At the state level, DBHDD's Substance Abuse Behavioral Health Plan is posted on the departmental website for review and comment and the plan is sent to the BHPAC for review. A few years ago, the Council voted to expand the role of the Council to a BHPAC and held meetings with the Director of the DBHDD Office of Addictive Diseases to discuss roles and functions of the Council related to the SABG and the overall planning and delivery of substance abuse services. The Council continues to work on further development of the BHPAC related to substance abuse representation. The leadership from the Addictive Disease Office regularly attends Council meetings and provides reports on delivery of substance abuse and prevention services in Georgia. In addition, there have been representatives from the Substance Abuse provider and advocacy community added to the Council as well as family members of persons with co-occurring disorders. The Council continues to focus on expansion of its substance membership representation and to educate

Council members of the needs of consumers with substance abuse and co-occurring treatment needs.

b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work? ☐ Yes No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? ☐ Yes No

3. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The Georgia BHPAC has been in existence for many years since there was a federal mandate to have a Council. The Council meets every other month and has ad hoc meetings as needed to conduct Council business. The Council Program Committee sets the agenda for each meeting which always includes an opening from a graduate of the RESPECT Institute. Graduates of this institute share their stories which help to inform Council members of the challenges and needs as well as successes of the individuals. Meetings also include opportunities for members to share concerns as well as educational information. There are also reports from DBHDD staff leadership from the Offices of Adult Mental Health; Children, Young Adults and Families; Recovery Transformation, Federal Grants and Cultural and Linguistic Competency; Deaf Services; and Addictive Diseases. In addition, the Council plans for presentations by service providers and site visits to stay abreast of new service delivery activities and programs. GBHPAC agendas and minutes from SFY19 are attached.

The Council has made a concerted effort to develop communication technology to keep the broader community and Council members aware of Council activities. To this end, a Council website has been developed as well as other use of social media. The Council has become more visible and is able to share information more broadly.

The Council By-Laws were updated in 2016 and 2018 to reflect the changes made to the GBHPAC. The amended 2018 By-Laws are attached. The duties and responsibilities of the Council are included in a recently revised new member orientation handbook. Council members actively support and participate in Mental Health Day at the Capitol, Substance Abuse Day at the Capitol, Suicide Prevention Day at the Capitol as well as Children's Mental Health Day. Also, during the legislative session and throughout the year Council members stay abreast of current issues and legislation, and advocate for the needs of adults with SMI and SUD, as well as children and adolescents with SED. There are regular reports at the Council meetings on state and national legislative issues pertaining to the target populations. Many Council members are also active members of their local Regional Advisory Councils (RACs) and some are members of the Leadership Council of the RACs.

The council reviews the Comprehensive Mental Health State Plan, the Substance Abuse Block Grant Plan and submits recommendations for modifications to the state. The Council serves as an advocate for people in recovery from mental health diagnoses, children and youth with serious emotional disturbances and other individuals with behavioral health challenges; and monitors, reviews and evaluates a plan for allocation and adequacy of behavioral health services within the state, makes recommendations for service improvements, and reviews the implementation reports for the mental health block grant and substance abuse block grant.

The Council has been involved in the development of the MHBG application by participating in meetings to review the priority areas, goals and indicators for this submission of the MHBG. Both the Child and Adolescent and Adult Mental Health committees held meetings to complete the review process and present their findings to the GBHPAC as a whole. A letter from the Council Chair is attached indicating the Council's participation in the MHBG application development process. In addition, agendas and minutes of meetings held in FY19 and the revised By-Laws are attached. The GBHPAC is also sent the draft of the goals and indicators for the SABG and have opportunity to disseminate, review and comment.

Please indicate areas of technical assistance needed related to this section.

None at this time.

Additionally, please complete the Advisory Council Members and Advisory Council Composition by Member Type forms.[70]

[70]There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

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Footnotes:

On behalf of the GBHPAC, DBHDD applied for and was selected for the 2018 State TA Leadership Academy offered by SAMHSA through the Advocates for Human Potential. In February, the BHPAC Executive Committee began participating in virtual learning community group meetings with other awardees. The Executive Committee of the GBHPAC and DBHDD MHBG State Planner participated in all state cohort calls, monthly state coaching calls and received two site visits from the Advocates for Human Potential. The purpose of the academy was to help state planning council teams build essential leadership skills among chairs, co-chairs, vice-chairs and other Council leaders. Topics included: Foundations for the Leadership Academy; Leadership with Vision; Decentralized Leadership; Collaborators and Catalysts; Culture and Diversity; Meeting Management; Future Leaders and Mentoring; and, Sustaining the Vision. The GBHPAC presented a summary of its project plan on an all state call in August 2018 and continues to make progress on completing the project plan.

GEORGIA BEHAVIORAL HEALTH PLANNING & ADVISORY COUNCIL

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August 24, 2018

Judy Fitzgerald
GBHDD Commissioner
2 Peachtree Street, N.W., 24th Floor
Atlanta, Georgia 30303

Dear Commissioner Fitzgerald:

The Georgia Behavioral Health Planning and Advisory Council (GBHPAC) has participated in the development of the priorities and indicators for the 2019-2020 plan as well as reviewed the application of this year's Mental Health Block Grant Program Plan. Our Georgia Department of Behavioral Health and Developmental Disabilities (GDBHDD) has kept us abreast of changes and updates with regard to writing the plan. Also, GDBHDD's sister agencies (see the list of involved state agencies) who are a part of our Council, have made every effort to assist GDBHDD in this time of ongoing change and improvement for Georgia's behavioral health system and its commitment to infuse recovery in all aspects of the delivery of services.

This continues to be a time of transition in the delivery of behavioral health services in the State of Georgia. As you know, our GBHPAC Committees have worked very closely this year in developing program and support for adults, children, young adults, and families. Our work this past year in developing a stronger Council and new leadership for the future has been impressive and given new energy to Council members to partner with the State in the direction and implementation of a plan.

The State has created new programs, expanded peer supports, housing, and collaborated with the Georgia Vocational Rehabilitation Agency to enhance supported employment services. There still are challenges ahead for child and adolescent services and the council is looking forward to future plans; The GBHPAC supports a greater focus on children and youth services and supports.

A few years ago, our Planning and Advisory Council conducted a survey of providers statewide, asking them if public mental health services were serving Georgia's children well. Our report, titled *Failing the Children*, revealed that it was not. One provider told us, "The more children I serve, the more money I lose." In a number of our public mental health agencies the cadre of children and adolescent providers had gone from 100+ to less than 5

Children and families were often unable to get the help they needed, with extremely negative life outcomes. A gradual rebuilding began to occur, then a Federal lawsuit in 2010 forced funds into the adult crisis system. That legal action is now completed and there is a strong will to do some serious rebuilding of services for what we now call Children, Young Adults and Families. DBHDD has redirected some funds to support school-based Mental Health, in Project APEX.

Our Behavioral Health Regional Advisory Councils statewide have just identified their top 3 priorities for 2019. Improved behavioral health services for children and their families is at the top of their list. Our State plan 2019 - 2020 adds volume to the call for serious investment and improvement.

The really good news is GDBHDD continues to move forward at a rapid pace.
GDBHDD's rapid pace includes behavioral health's Community Behavioral Health Core Provider Initiative, and in the most innovative of transformations, the designation of an Administrative Service Organization (ASO) to centralize and consolidate behavioral health services throughout the state. The ASO will also facilitate the GDBHDD to effectively monitor services in 'real time' to provide easy access to high quality health care as is the mission statement and mission of the GDBHDD.

The Georgia Behavioral Health Planning and Advisory Council is so grateful for your continued support and leadership. We remain a committed partner with GDBHDD to ensure that all Georgians who need services get what they want and need, to recover and maintain their wellness. The council will continue to advocate for people with behavioral health concerns regardless of age, race, ethnicity, gender or religious preference.

Sincerely,

Sandra Mullins

Sandra A. Mullins

Chairperson

BY LAWS OF THE

GEORGIA BEHAVIORAL HEALTH PLANNING & ADVISORY COUNCIL

ARTICLE I: AUTHORITY

The Georgia Mental Health Planning and Advisory Council was established in 1989 according to the Public Health Services Act, Title XIX, Section 1914 (b) resulting from Public Law 106-310 by the Division of Mental Health, Developmental Disabilities and Addictive Diseases within DHR established in OCGA Chapter 37-2. The Georgia Behavioral Health Planning and Advisory Council continues in this capacity under the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) established in OCGA Chapter 37-1 in 2009.

ARTICLE II: PURPOSE

The purpose of this council is to review the Comprehensive Mental Health State Plan, the Substance Abuse Block Grant Plan and to submit recommendations for the modifications to the State: to serve as advocate for people in recovery from mental health diagnoses, children and youth with serious emotional disturbances and other individuals with behavioral health challenges; and to monitor, review and evaluate, not less than once each year, a plan for the allocation and adequacy of behavioral health services within the state, make recommendations for service improvement, and review implementation reports for Mental Health Block Grant and Substance Abuse Block Grant.

ARTICLE III: SCOPE OF COUNCIL ACTIVITIES

1. The scope of this council shall encompass the review of the Mental Health Block Grant and submit to the State any recommendations for modifications to the plan. The Council may utilize whatever information and assistance that is available within the DBHDD and other agency partners to effect change following such examination and advocacy.

2. Monitor, review and evaluate the allocation and adequacy of Mental Health Services.

3. Advocate on behalf of people in need of Behavioral Health Services driving toward the goal of recovery.

ARTICLE IV: MEMBERSHIP

A. The Council will be composed of residents of the state including representatives of state agencies with respect to mental health, education, vocational rehabilitation, criminal justice, juvenile justice, housing, social services, medicaid, aging services, and addictive disease.

B. PHS Act, Title XIX, Part B, Section 1914 (b) further specifies that not less than 50 percent of the members of the Council will be individuals who are not State employees or providers of mental health services:

Updated 05/7/18

1. The Commissioner of DBHDD, DBHDD Director of Community Relations and DBHDD Director of the Office of Recovery Transformation.

2. One organizational membership for the Georgia Mental Health Consumer Network, Mental Health America of Georgia, National Alliance on Mental Illness - Georgia, Georgia Parent Support Network, Georgia Council on Substance Abuse, and Georgia Advocacy Office.

3. Two at-large representatives, who are adults in recovery from serious and persistent mental illness, and two at-large representatives, who are adults in recovery from addictive disease challenges, nominated by the membership committee and confirmed by the Council.

4. Two at-large Children and Youth (C & Y) family member representatives; caring for a C & Y living with mental health and/or addictive disease challenges; one family representative for C & Y living with a mental health diagnoses and one family representative of C & Y living with addictive disease challenges. There will be two at-large C & Y representatives; one in recovery from mental health diagnoses and one in recovery from addictive disease challenges. They will be nominated by the Membership Committee and confirmed by the Council.

5. Chair of DBHDD Statewide Leadership Council.

6. Council membership will include a significant number of people who are Adults, Children, Youth, and Family Members that have lived experience with behavioral health diagnoses.

C. Council membership shall consist of; general representation from public agencies and private entities, concerned with the needs, planning, operation, funding and use of behavioral health services and related supported services.

D. The Council shall consist of not less than 24 members. Members can be appointed for a total of two (2) consecutive terms. At the end of the first three-year-term, the Membership Committee may ask the council member if they are willing to serve a second three-year-term. If the council member agrees, the Membership Committee will report to the Council Chair, who will announce their acceptance of a second term. If the council member does not wish to serve a second term, the Membership Committee will conduct a search for nominees to submit to the Council for recommendation. After one year off the Council, a former member can be reappointed for up to two (2) consecutive terms. State employees who represent agencies on the Council are exempt from term limits. They will serve until the fail to meet the Council attendance policies and/or a different representative is appointed by the agency they represent. Each year, at the first meeting held after September 30, or when there is a vacancy, the Membership Committee will present nominations as prescribed above. After confirmation by the Council, the proposed list of new members will be sent to the Commissioner of the DBHDD with a recommendation for appointment. Members whose terms expire will be removed from the council's membership list when the Commissioner appoints the new slate of members. Members representing state agencies who withdraw will notify their agency director and request that she/he notify the council chairperson of the reappointment. Each member shall keep confidential all sensitive

information pertaining to council members and applicants, both during and after serving on the council.

E. Vacancies shall be filled by council recommendations to the Commissioner of the DBHDD for appointment to fill periodically occurring vacancies. The Council will annually review the agencies represented on the council and make needed additions/deletions.

F. The council members shall serve without compensation but shall be reimbursed for any and all actual necessary expenses incurred in connection with the performance of duties authorized by the council. After a nomination is approved by the council and sent to the Commissioner for official appointment, the nominee is entitled to expense reimbursement.

G. In order to ensure that the Council is representing everyone, member attendance at all council meetings is expected. Understanding that conflicts will exist, the council will accept occasional absences. Sign in sheets for attendance will be confirmed by the secretary. The Council has developed the following guidelines.

MEMBERSHIP ATTENDANCE SHALL CONSIST OF:

1. Attendance at all scheduled meetings every year. If a member is absent for two (2) consecutive meetings, a letter notifying the member of his/her potential removal will be generated. If the member is a state employee, a letter to his/her Commissioner will be generated. If a member is absent for more than two (2) of any six (6) meetings in a calendar year he or she will be referred to the Executive Committee (EC) for follow up and recommendations. The (EC) shall take into account any and all events beyond the members control such as illness or hardships prior to making a recommendation. If the recommendation is removal, then the case is submitted to the membership committee for search of a replacement. Absent is defined as not being present and not represented by a permanent alternate. In order to vote on an issue, the council member or permanent alternate must have been in attendance, as defined above, for the discussion of the issue.

2. If a council meeting date is changed with less than 20 day notice to members, an absence at that meeting will not be recorded as an absence.

3. If a member fails to meet obligations of membership, as detailed above or as determined by the Executive Committee (EC) after being referred for review, the Membership Committee shall request council recommendations to be vetted and to submit to the Commissioner of DBHDD to appoint a replacement for the member.

H. The Council is consciously and proactively inclusive of all areas of diversity including, but not limited to, age, race, ethnicity, creed, color, sex, gender identity, sexual orientation, marital status, religion, spirituality, disability, national origin, military/veterans status, or behavioral health issues.

Updated 05/7/18

I. Each member shall designate a permanent alternate to attend council meetings in the membership place in the event of the members absence and to vote the member's proxy if necessary. Permanent alternates may attend council meetings with their member but may not vote if the member is present at the meeting. Designation of permanent alternate by a member shall be made in writing to the Council Chairperson Staff.

J. Visitors may attend council and committee meetings, visitors do not have voting privilege.

ARTICLE V: QUOROM

One-third of the Council's voting members shall constitute a quorum. The action of a majority of a quorum present at the time of voting shall constitute the action of the Council. All members or permanent alternates attending in the place of members are entitled to vote. The Chair has no vote unless there is a tie.

ARTICLE VI: OFFICERS

A. The Chairperson shall be the principle officer of the GBHPAC. The Chairperson shall preside over all the meetings as needed, appoint committees and generally supervise and direct all actions of the Council with assistance of the Council and staff from DBHDD. The Chairperson shall be elected by the council membership and shall hold office for three years and as necessary appoint members to officer vacancies to complete a term.

B. There shall be a Chair Elect whose term runs concurrent to the Chairperson. The Chair Elect shall represent the Chair during his/her absence at council meetings or other events when the Chairperson would have represented the Council. The Chair Elect will take over as Chair when the Chairperson's term expires or the Chairperson leaves the Council for other reasons.

C. At the September meeting prior to the Chair Elect assuming the Chairperson's role, a new Chair Elect will be elected by the membership. The nominating committee will present a slate of qualified nominees for this position and any other positions whose term is scheduled to end. The Chair Elect must be someone who has been a member a minimum of one year. Terms can be extended to allow for services as an elected officer of the Council. The Chair's term of office can be extended to allow for a term as past chair.

D. There shall be two Vice-Chairpersons elected by the Council each to serve three year terms. One Vice- Chairperson shall be elected to represent children and young adults with behavioral health issues and their families. One Vice- Chairperson shall be elected to represent adults with behavioral health issues. These Vice-Chairpersons shall hold an annual meeting with the Child and Adolescents Committee and the Adult Behavioral Health Committee in coordination with the designated DBHDD representative to review the State's Annual Plan for mental health services and report back to the full Council any recommendations and/or comments. The two Vice-Chairpersons terms may be staggered to avoid a full range of leadership in the same year.

Updated 05/7/18

E. A Secretary shall be elected by the Council for a three- year term to oversee recording and distribution of minutes of meetings and written announcements of all meetings. The secretary shall perform other such duties as the chairperson directs and shall utilize assistance by the council's administrative assistant.

ARTICLE VII: ADMINISTRATIVE ASSISTANT

A. An Administrative Assistant shall be retained by the Council. The Administrative Assistant shall administer the needs of the Council and as the Chairperson directs. Under the direction of the Secretary, the Administrative Assistant will record the meeting minutes and distribute the minutes of the meetings and written announcements of all meetings.

B. The Administrative Assistant will give assistance to the staff liaisons of the DBHDD with all information about council business and assist with the Mental Health Services Block Grant issues that affect the Council and any other duties as instructed by the Council Chairperson.

ARTICLE VIII: MEETINGS

A. The GBHPAC shall meet a minimum of four times a year. Members shall be notified in writing of the date, time and place of the meeting at least twenty days (20) in advance.

B. Special meetings of the Council may be called by the Chairperson as necessary to fulfill the purpose of the Council.

ARTICLE IX: COMMITTEES

A. The GBHPAC shall have an Executive Committee to include at a minimum the Chairperson, the Chair-elect, two Vice-chairpersons and the Secretary. Additional members of the Executive Committee may include chairpersons of standing committees and past-chair. The Executive Committee shall be responsible for the formulation of the meeting agenda for the full Council and for the conduct of such Council business as may arise and require attention at times other than during regular meetings of the full Council.

B. Standing committees are: Adult Behavioral Health, Children, Young Adults and Families, Planning Committee, Advocacy Committee, Nominating and Membership Committee.

C. The GBHPAC shall have such standing and ad hoc committees as the council shall deem necessary for the proper conduct of its business. Such committees shall be appointed by the Chairperson and shall report directly to the council.

D. The Council shall have the power to abolish or create committees by two-thirds vote of the members present. Persons who are not members of the Council may serve on committees.

ARTICLE X: AMENDMENTS

Updated 05/7/18

These by-laws may be amended by a majority vote of a quorum at any meeting of the GBHPAC, provided that the proposed amendment shall have been submitted in writing to the by-laws committee at least 30 days prior to such meeting.

Updated 05/7/18

GEORGIA BEHAVIORAL HEALTH PLANNING & ADVISORY COUNCIL

The Carter Center
453 Freedom Parkway
Atlanta GA, 30307
July 10, 2018
AGENDA

10:00 a.m.	**Welcome and Introductions – Sandra Mullins, Chair** Moment of Silence Respect Institute Graduate – Michelle Boatright
10:30 a.m.	**Sharon Jenkins Tucker introduction of Facilitators – Ted Johnson & John Hudgens**
10:35 a.m.	**How to strengthen Council leadership?**
11:45 a.m.	**How to strengthen Council engagement?**
12:15 p.m.	**Lunch**
1:00 p.m.	**How to enhance the relevance and visibility of the Council?**
2:00 p.m.	**How to strengthen the role of the Council with the State BH agency?**
3:00 p.m.	**Summarizing the day's questions and discussions**
4:00 p.m.	**Adjourn for the day**

July 11, 2018

10:00 a.m.	**Welcome and introductions – Sandra Mullins, Chair** **Moment of Silence**
10:10 a.m.	**How to strengthen Council agenda and meeting quality?**
11:10 a.m.	**How to strengthen committees?**
12:15 p.m.	**Lunch**
1:00 p.m.	**Review: How to use information from the two days to create an action plan**
3:00 p.m.	**Adjourn**

GEORGIA BEHAVIORAL HEALTH PLANNING & ADVISORY COUNCIL

The Carter Center
453 Freedom Parkway
Atlanta, GA 30307
July 10-11, 2018
10:00am – 4:00pm
Meeting Minutes

Members Present: Linda McCall, Sandra Mullins, Felicia Hardy (for Yvette Sangster), Jean Toole, Sue Smith, Pierluigi Mancini, Bertrand Brown, Sharon DeMille, Jean Olshefsky, Rebecca Blanton, Jewell Gooding, John Shereikis, Faye Taylor, Sherry Jenkins Tucker, Prince Moorman(for Cassandra Price), Lucy Hall, Erika Johnson, Ron Koon, Amy Kuhns, Cynthia Wainscott, Neil Campbell, Mary Shuman (for Tony Sanchez), Thom Synder

Department Staff: Dawne Morgan, Jill Mays (for Terri Timberlake), Danté McKay

Guest: Anthony Williams, Michelle Boatright, Colleen Mousinho, Harvinder Makkar, Ted Johnson, John Hudgens

Introductions, Moment of Silence

The Chair, Sandra Mullins called the meeting to order and commenced with introductions followed by a moment of silence.

Respect Institute Graduate: Michelle Boatright

Michelle Boatright is a Respect Institute graduate and shared her recovery story entitled redeemed. The Respect Institute empowers those in recovery to share their recovery journeys, educating people about people with mental illness and helping to eliminate stigma.

The Respect Institute works in collaboration with multiple agencies and organizations such as GDBHDD, GMHCN, and MHA of Georgia.

Sharon Jenkins Tucker introduced facilitators – Ted Johnson & John Hudgens

- Ted Johnson reviewed the values of the Council which are hope, respect, recovery, collaboration, inclusive and committed.
- Ted then asked the Council how Council leadership can be strengthened. The responses were engagement (work, each other, community), responsiveness, mission, vision, direction, focus, communicator, passion, compassion, connector, empowers others, understanding past(but visionary), strategic thinking, analytical, thick-skinned, diplomatic, innovative, takes initiative, pulse, purpose driven, mover/shaker, trustworthy, fearless.

- Sandra Mullins responded to Council members' questions regarding the role of the Council as it relates to the Council's mission and vision.
- Sue Smith shared a brief history of the Council and how children's representation became a part of the Council. This was followed by Cynthia Wainscott who explained how addictive disease came to be represented on the Council as well and some other things it has accomplish since its beginning.
- Ted reviewed ways in which we can strengthen Council engagement: please see PowerPoint

Day 1 Georgia
Onsite Visit Retreat

- Sandra Mullins gave a short farewell speech gift to Dawne Morgan who is retiring from DBHDD and her role as liaison to the GBHPAC.
- Dawne Morgan shared with the GBHPAC a short history of how the Council has evolved: it started as a requirement for the block grant from the federal government, the feds mandated that the states had to have an advisory Council. A mental health planning and advisory council was formed out of the federal mandate. A great relationship formed between the state and the mental health and advisory Council. The state was always able to showcase the work done with the Council to the federal government. Georgia was seen as a state that was innovative and led the rest of the states in many ways. The Mental Health Planning and Advisory Council eventually became the Behavioral Health Planning and Advisory Council after addictive disease was included. In partnership with the Council funding was obtained to provide for services for children. The peer movement also came about during this period and now there are peer specialists for adults, youth and parents.
- Ted then asked the Council how they know that they are relevant. Some of the responses given were, broad perspectives, people know what it is, what it does, its impact, It has specific impact in many areas, the Council's work is known beyond Georgia, it is relevant if it listens to the needs of the communities, it documents accomplishments and share that information, provides next steps in response to current and emerging needs, it's relevant if all members feel engaged, and understood their roles.
- Another question Ted asked was to whom do you want GBHPAC to be visible to? Responses were providers, legislators, stakeholders, families, other advisory groups, other agencies and leaders, the feds, people on behalf of whom the work is being done, young adults,
- The Council commented, other ways to increase visibility such as grants, other social media, statewide organization and events, partner with groups, do public" campaigns, tables at exhibit area at conferences, pop-culture, ???, Increase the number of young people on the Council, to engage understand their perspectives and ideas, think broadly in terms of young people, identify ways to support involvement, go to younger groups.
- Division reports for July are below.

BHPAC Office of Adult Mental Health
BHPAC Office of Addictive Diseases 7
BHPAC Office of Children Young Adu
OCYF April Infographic 2018.pd
SOC Infrastructure Brief_4-9-18.pdf
BHPAC Office of Federal Grant Progr

With no other announcements or business, the Chair called the meeting to an end at 4:00pm.

Meeting Adjourned

July 11

Members Present: Linda McCall, Sandra Mullins, Yvette Sangster, Jean Toole, Sue Smith, Pierluigi Mancini, Bertrand Brown, Sharon DeMille, Jean Olshefsky, Jewell Gooding, John Shereikis, Faye Taylor, Prince Moorman(for Cassandra Price), Lucy Hall, Ellyn Jeager, Ron Koon, Amy Kuhns, Cynthia Wainscott, Mary Shuman (for Tony Sanchez), Thom Synder,

Department Staff: Jill Mays (for Terri Timberlake), Danté McKay

Guest: Colleen Mousinho, Harvinder Makkar, Jennifer Hogan, Felicia Hardy, Ted Johnson, John Hudgens

Introductions, Moment of Silence

The Chair, Sandra Mullins called the meeting to order and commenced with introductions followed by a moment of silence.

- Ted mentioned it is very important that newcomers have mentors to guide them on the Council
- Pierluigi Mancini stated, the department division reports should be actionable. He commented that in the past the Council usually requested information from the state that the Council felt was informative. Such as what percentage of adults received a certain kinds of services etc.
- Ellyn Jaeger recommends that the Council should not wait until the November elections. Once the outcome the Republican runoff has been decided the chair of the Council along with a few members should make it a point to visit the winner of the Republican race to introduce them to GBHPAC as well as make a point to visit Stacy Abrams as well.
- Ted asked what are and the components of a committee. The responses were, they should be a purpose for each committee (related to vision and mission). Size/membership - how many individuals on the committee. If it's too large that may hamper progress and if it's too small nothing gets done. Representation: stakeholders will be impacted by the issues. This was followed by the question, does someone without children get to serve on the children's committee? Perhaps it depends on the person's interest. Another aspect of the committee is meeting structure . Additionally skill sets, knowledge, balance, good listener, have time to work, life of a committee, resources.

- What should GBHPAC committees be composed of? services (access, utilization, and availability), legislative, nominations, membership, prevention, Age groups (child, young adults, adults, aging)
- Why is it important that People who are not Council members may serve on committees? - Ted explain this is important because they are volunteers, they get acquainted with the Council, and it's a good way to recruit new members, it's a good way to identify people who will be good members. Please see PowerPoint below.

Day 2 Georgia
Onsite Visit Retreat

With no other announcements or business, the Chair called the meeting to an end at 3:00pm.

Meeting Adjourned

GEORGIA BEHAVIORAL HEALTH PLANNING & ADVISORY COUNCIL

Georgia Parents Support Network
1395 Metropolitan Pkwy SW
Atlanta, GA 30310
September 11, 2018
AGENDA

10:00 a.m. **Welcome and Introductions – Sandra Mullins, Chair**
Moment of Silence
Respect Institute Graduate – Toyia Mather

10:30 a.m. **Vote on Updated By-laws – Jean Toole**

11:00 a.m. **Division Updates**
Adult MH – *Terri Timberlake*
Addictive Diseases – *Prince Moorman*
Office of Recovery Transformation – *Mary Shuman*
CYF – *Danté McKay*
Deaf Services – *Candice Tate*
Federal Grants – *Dawne Morgan*

11:45 a.m. **GBHPAC Announcements – Sandra Mullins**

12:15 p.m. **Lunch**

1:00 p.m. **DOJ Updates and Housing – Cynthia Wainscott**

2:00 p.m. **TA Call-In with SAMHSA**

3:00 p.m. **Meeting Adjourned**

GBHPAC GEORGIA BEHAVIORAL HEALTH PLANNING & ADVISORY COUNCIL

Georgia Parents Support Network, Inc.
Atlanta, GA
Meeting Minutes
September 11th, 2018

Members Present: Rebecca Blanton, Bertrand Brown, Neil Campbell, Sharon DeMille, Jewell Gooding, Alan Huth, Erika Johnson, Ron Koon, Michael Link, Linda McCall, Sandye Mullins, Jean Olshefsky, Bob Poston, Tony Sanchez, Yvette Sangster, John Shereikis, Sue Smith, Faye Taylor, Jean Toole, Cynthia Wainscott, Patrick waters

Members Present by Permanent Alternate: Monica Johnson (for Judy Fitzgerald), Jennifer Hogan (for Thom Snyder), Yomi Makanjuola (for Cassandra Price)

Members Absent: Eleanor Brown, Mary Davey, , Bradley Grover, Ellyn Jeager, Amy Kuhns, Pierluigi Mancini, Keith Bostick, Steve Spivey, Sharon Jenkins Tucker

Department Staff: Jill Mays, Danté McKay, Dr. Terri Timberlake

Guest: Toyia Mather, Aisha Northington

Welcome and Introductions

Sandye Mullins called the meeting to order and ask those in attendance to introduce themselves. After the introductions the Chair asked for a moment of silence to remember those whose lives were taken on 9/11/2001.

Respect Institute Graduate: Toyia Mather

Respect Institute speaker Toyia Mather shared her recovery story entitled "Come out Come out Wherever You Are". The Respect Institute empowers those in recovery to share their recovery journeys, educating people about mental illness and helping to eliminate stigma.

Review and Approval of Minutes

The Chair Sandye Mullins made a motion to approve the July minutes. Minutes were approved.

Commission's Update: Monica Johnson

Monica introduced Jill Mays as the official department liaison to the Council and explained why Jill's official title has been changed from Director of Federal Grants and Special Initiatives to Director of Federal Grants and Cultural Linguistic Competency. Monica said Cultural Competency has been a frequently requested service under many of the grants that the department receives. However, there have been a number of barriers to being able to completely satisfy this particular requirement such as funding and other resources. Jill's office will be in a position to implement programs that provide cultural and linguistic competency training. Monica also stated that September was National Recovery Month and Suicide Prevention Month. The department is embarking on a Suicide Prevention Campaign

with Cumulus Radio, starting in the month of September and running through the holiday season, which is peak time for suicides. This partnership is with The Bert Show on Q100 radio station in Atlanta. PSA's will be run on The Bert Show, as well as in movie theaters. It was also revealed that there has been a dramatic increase in the number of people served by supported housing. In partnership with DCA, DBHDD has been able to expand the federal and state housing voucher program. Monica conveyed that Gateway Behavioral Health Services in Brunswick has one of the best crisis service centers in the State. One of the key factors in their success is having a CPS available to support the person in crisis the moment they walk in the door.

Office of Children, Young Adults and Families (OCYF) Partnership with GSU: Danté McKay

Danté spoke about his collaboration with The Center of Excellence for Children's Behavioral Health (COE) at Georgia State University, there were three areas covered. The first area that was covered was System of Care Values and Principles, this area has evolved over the last 30 years. There are certain values and principles that can be pulled out of the framework such as; Spectrums of Community-Based Services and support that is organized into a coordinated network. This network builds meaningful partnerships between families and youth and addresses cultural and linguistic needs in order to improve functioning at home at school, in the community and throughout life. Over time these values and principles have been used to form Georgia's formal system of care framework, the Behavioral Health Coordinating Council which is immortalized in Georgia law 37-2-4. The purpose of the Council is identifying overlapping services regarding planning and policy issues in the behavioral health system for both kids and adults. The other two areas are Georgia System of Care Framework and Georgia System of Care State Plan. Georgia State University provides backbone support for a variety of areas including IDT and data collection. The work group for school based mental health collected data from 700 school counselors throughout the State. It was discovered that one third of the schools surveyed had some sort of school based mental health services such as counselors embedded in the school, prevention or self-care related initiative. The payer determines a child access to services. In order to help families and youth understand the system, a step-by-step navigation guide was created for them from the perspective of families and young adults. Danté spoke about the Governor's Commission on Children's Mental Health. One of the recommendations was the expansion of the Georgia Apex Program in the last legislative session this recommendation received $4.29 million. Danté mentioned the primary functions of the IDT is to provide a strategic roadmap for Children Services. There is work that is relational to evidence based practices as well. References are housed on The Center of Excellence website. The timing of The System of State Care Plan aligned well with the forming of the Commission. This led to eight recommendations being returned by the Commission. Some of the recommendations were to further expand the APEX program. There was also a recommendation to form both supportive employment and supportive housing programs. Over $3 million was set aside to form an evidence informed model, which allows for more flexibility. Included was more funding for peer support, which allowed for an increase in staffing, youth and parent CPS. Future crisis respite homes will be funded as well. More trainings will be offered, including Trauma Informed Care. Temporary funds were given to sustain Wraparound services and extended eligibility has been given. The Opioid recommendation received $1 million and the Suicide Prevention Program received $1.4 million. Funding will also become available to ensure there is staff available to answer the warmline at The Georgia Council on Substance Abuse 24 hours a day, as opposed to the restricted hours they currently have. Local Interagency Planning Teams (LIPT) were created in 1990. These multi- agency teams meet to provide supports and

services that are all voluntary and unfunded. Currently, there are more than 130, throughout the State of Georgia. Membership includes the parents, youth, community and mental health agencies, department of family and children services, GVRA etc. Danté mentioned that the Block Grant has supported services that are a part of the continuum of care and the goal is to move them to sustainability. *For further information see report embedded below:*


09.11.18_BHPAC.pdf


SOC_Poster.pdf

Committee's Report

Cynthia Wainscott, Chair of CYF Committee, stated the committee has decided on bi-monthly meetings, which would be held the first or last week of the month. There will be phone calls before each meeting. The agenda for the first meeting includes understanding the rules of Block Grant, goal setting and developing priorities.

Jean Olshefsky Chair of Adult Committee had the opportunity to meet everyone. This committee will meet every other month. October and December meetings dates have already been set. Meetings will discuss priorities and agendas. Also, learning what's covered in the Block Grants, developing leadership and others to invite in to further the GBHPAC Mission. As well as finding out the exact role of GBHPAC under the block grant.

Policy and Legislative Report: Jewell Gooding

Jewell talk about a lawsuit against the Affordable Care Act (ACA) regarding the constitutionality between Texas and Azar Different strategies of closing the Medicaid coverage gap is being considered with some conservatives even considering alternatives like waivers. Grady Hospital is doing a pilot program in reference to the waivers. Another issue of concern is the rural hospitals. Due to the low population base they are not making enough money to survive and are therefore closing or at risk of closure. Certificate of Need conversation has related to the hospitals. There will be more information coming on the certificate of need. Some of the issues brought from previous legislative sessions, are retrospective ER policies, there is also a joint study committee on Tetrahydrocannabinol (THC) low medical oil access. As well as another study committee on Kratom to examine the effects is a drug that is highly addictive that is used to get people off of other drugs. There are also study committees examining service animals for those who are mental and physically impaired. Study committee for dyslexia. Georgia Physician Practicing Association (GPPA) is ready to look at getting psychiatric advanced directives passed, this bill may be reintroduced and helps with recovery oriented practices. Another bill that may pass through this year is for Emergency Medical Technician (EMT) and Emergency Medical Services (EMS), to looking at what their role is exactly in the public mental health system versus trying to force a particular intervention (1013). Opponents are working hard to try to help Senators understand the consequences of trying to implement interventions of such magnitude. Criminal Justice Reform is being worked on by MHA of GA and engaging different community groups to help support or maximize the resources that do exist. Parity is reaching its 10thyear. In 2008, there was the mental health parity and insurance act, called the Better Parity Law. This law required insurance to cover illnesses of the brain such as depression and addiction, no more restrictively than illnesses of the body like cancer and diabetes.

Divisions Updates

Adult Mental Health: Dr. Terri Timberlake

Dr. Timberlake shared that Gateway Behavioral Health Services will be operationalizing the Savannah Behavioral Health Crisis Centers (BHCC) by early summer of next year. Additionally, Avita has also been looked at to provide the next be BHCC in the Gainesville area. DBHDD will provide funding to the CSB's to hire Housing Outreach Coordinators who will support individuals who are transitioning from prison, jails and emergency rooms to provide supported housing. The Housing Outreach Coordinators will not be providing services to individuals who are receiving outpatient services. She also mentioned that twelve positions across specific CSB's have been funded for the Housing Outreach Coordinators. The first housing outreach coordinator was hired in December, the last was hired in April. *For further information see report embedded below:*

BHPAC Office of Adult Mental Health

Addictive Diseases: Yomi Makanjuola

Yomi (Director of Treatment Services for the Office of Addictive Diseases) was filling in for Prince Moorman. Yomi reported The State General Assembly gave the Office of the Diseases $40 million for recovery supports as oppose to treatment. There will be a similar mechanism put in place for individuals to receive recovery support, as was the case with teenagers and clubhouses. Georgia Council on Substance Abuse will be the technical assistance provider for this project. There will also be a residential treatment program for young adults. It will be the first in the State of Georgia it will target youth from age 18 to 26. *For further information see report embedded below:*

BHPAC Office of Addictive Diseases 9

Office of Recovery Transformation: Tony Sanchez

Tony mentioned that September is National Recovery Month and there will be 20 events scheduled across the State for the entire month. These events will be funded through DBHDD's Office of Addictive Diseases. Tony added that each of the Addiction Recovery Support Centers are required to be run by individuals with the credential of CPS-Ad or CARES. In addition, the Executive Director of these organizations starting salary will be over $50,000 with the support staff salary starting at over $35,000. Tony hopes the salaries at the Recovery Support Centers will have a broader effect of raising salaries for CSB's and other providers. Tony then mentioned that the peer mentors who are trained by Georgia Mental Health Consumer Network, provide support to individuals transitioning from state hospitals back into the community. These positions were originally part-time and now there is funding available to provide the peer mentors who work at three of the five State hospitals full-time positions with the goal of making all the peer mentors at the five hospitals full-time employees. One of the aims of these full-time positions is to allow for more one-on-one time with the peer mentor and individuals receiving services. *For further information see report embedded below:*

2018.09.11 BHPAC Office of Recovery Ti

Children, Young Adults, and Families: Danté McKay

Danté mentioned that there is a Southeast School Based Mental Health Coalition that includes all the South Eastern States. Danté said he is excited that Georgia is a part of this group and look forward to contributing to the coalition and also learning from them. Another development Danté spoke about was the four mental health juvenile courts. The State System of Care program is looking to provide better support to the juvenile mental health courts. The four courts are located in DeKalb, Fulton, and Chatham and Henry counties. *For further information see report embedded below:*

BHPAC Office of Children Young Adu

SOC Infrastructure Brief_4-9-18.pdf

SOC_State Plan Brief.pdf

Action Item: Danté suggest inviting the Center of Excellence to do a presentation for BHPAC

Office of Federal Grants: Jill Mays

Jill said that the First Episode Psychosis Project has started a new program and New Horizons in Columbus, Georgia. Staff training and outreach will begin the in the month of September. Furthermore, the DBHDD completed its work with NASMHPD for the Transformation Transfer Initiative which centered on Recovery Oriented Cognitive Therapy (CTR). Providers across the State were trained in CTR. Jill pointed out that not only clinical staff was trained in CTR, but peers as well. SAMHSA is changing the way they do technical assistance contracts. They are working on a regional system where the technical assistance dollars would go to universities who would then hire consultants to provide TA. Regarding the Block Grant the mini-application for 2019, Jill said it was submitted on September 4. There were new Block Grant rules pertaining to Behavioral Health Planning Council composition. One of the stipulations were that a council member cannot represent two categories. For example, an individual who is a provider cannot also be listed as someone in recovery. All Council members can only have one assigned role. Jill also announced that DBHDD was awarded to large grants. The first is called Georgia strong ($3.1 million) spanning three years for intensive outpatient services for new mothers with substance abuse challenges. This program will be housed at Hope House. It will cover individual and group substance abuse counseling, parenting support and education, employment and educational assistance, family support and education, Peer to peer support, relapse prevention education, intensive case management, transportation, referral services, childcare and housing assistance, linkage to OB/GYN psychiatric care and home visits by nurse and a parenting coach. They are slated to serve 136 women over the life of the grant and offer statewide services. The second grant is four year $11.3 Million grant from SAMHSA to expand the System of Care project to rural communities. DBHDD will be working with Aspire and CSB of middle Georgia to carry out this project. This project should be up and running by December. *For further information see report embedded below:*

BHPAC Office of Federal Grant Progr

Action item: Jill suggest discussing these two large grants further during the January meeting.

New Businesses and Announcements

Sandra Mullins: GBHPAC will be looking into revising its orientation manual. In addition, we will be looking at getting new individuals involved in the Council or to serve on the committees, along with creating a website for the Council. The Council will be looking at these issues starting in January. The consultants that facilitated GBHPAC March and July retreat made a recommendation for different department and divisions to give reports to GBHPAC. As an example, the Department of Education can give a report once or twice a year as well as other state agencies that have a seat on the Council. Please collaborate with Jean Toole if you're interested in presenting a report from your agency.

Jewell Gooding: Mental Health America of Georgia launching the mental health awareness campaign for World Mental Health Day on October 10. MHA of GA is currently looking for individuals who would like to discuss the current state of their mental health. The goal is to help people have intentional conversations in the community about mental health.

Jill Mays: From the Office of Prevention, the Governor's Red Ribbon Campaign will kick off on October 18 at the Barnes amphitheater in Mableton. Jill also acknowledged Nakia Valentine, A DBHDD employee who suddenly passed away. Nakia was the Director of Garrett Lee Smith Suicide Prevention Program. DBHDD's Office of Prevention has established Youth Suicide Prevention Leadership award in Nikita's name. This information is in your packet and how to nominate a deserving youth. DBHDD's collaboration with other departments is announcing its annual 5K recovery run/ walk at Grant Park.

Jean Olshefsky: GCAL was featured on CNN in an article and on video during International Suicide Prevention Week.

Faye Taylor: NAMI Georgia has three walks scheduled for October. Two of the walks will be on October 6.The first will be at Atlanta Clark University circling around the Capital and the second will be in Moultrie, Georgia. The third walk will be held in Gainesville, Georgia.

Cynthia Wainscott: Cynthia created a presentation about what happened in Georgia because of the DOJ settlement. She also said we need to celebrate what has happened and the amazing transformation that occurred in Georgia as a consequence of the settlement. *For further information see presentation below:*

Wainscott Panel Presentation.pptx

Meeting Adjourned

GEORGIA BEHAVIORAL HEALTH PLANNING & ADVISORY COUNCIL

GBHPAC vision is "*To be a leading force that strives for an accessible, affordable, comprehensive, and integrated recovery-oriented behavioral health system that cultivates and supports healthy and diverse communities in a culturally and linguistically inclusive manner.*"

GBHPAC mission is "*To bring individuals representing children, adults, peers, and families together to educate, advise, advocate, and monitor the behavioral health system to ensure an effective recovery-oriented system of care.*"

Care and Counseling Center of Georgia
1814 Clairmont Rd
Decatur, Georgia 30033
November 13, 2018
AGENDA

10:00 a.m.	**Welcome and Introductions – Sandra Mullins, Chair** • Moment of Silence • Respect Institute Graduate – Lilian Davis • Public Comment **Approval of Minutes for September 2018**
10:30 a.m.	**Expectations for the next year**
11:00 a.m.	**Committee's Reports – Areas Of Interest, Challenges and Setting Goals** • CYF committee – Cynthia Wainscott • Adult Behavioral Health Committee – Jean Olshefsky • Advocacy Committee – Jewell Gooding and Neil Campbell • Nominating and Membership Committee – Jean Toole
12:00 p.m.	**Lunch**
12:20 p.m.	**Commissioner's Update – Judy Fitzgerald**
1:00 p.m.	**Program**
1:30 p.m.	**What are You Proud of and Challenges for the New Year ?** • Adult MH – *Terri Timberlake* • Addictive Diseases – *Prince Moorman* • Office of Recovery Transformation – *Tony Sanchez* • CYF – *Danté McKay* • Federal Grants Data Reports – Jill Mays
2:00 p.m.	**New Businesses and Announcements** • Orientation of Members in January 2019
3:00 p.m.	**Meeting Adjournment**

GEORGIA BEHAVIORAL HEALTH PLANNING & ADVISORY COUNCIL

Care and Counseling Center of Georgia
Decatur, GA
Meeting Minutes
November 13, 2018

Members Present: Sharon DeMille, Judy Fitzgerald, Jewell Gooding, Lucy Hall, Alan Huth, Erika Johnson, Amy Kuhns, Pierluigi Mancini, Linda McCall, Sandye Mullins, Jean Olshefsky, Yvette Sangster, Sue Smith, Thom Snyder, , Jean Toole, Cynthia Wainscott,

Members Present by Permanent Alternate: Vickie Cleveland (for Rebecca Blanton), Prince Moorman (for Cassandra Price), Colleen Mousinho (for Keith Bostick), Mary Shuman (for Tony Sanchez)

Members Absent:, Bertrand Brown, Eleanor Brown, Neil Campbell, Mary Davey, Bradley Grover, Ellyn Jeager, Ron Koon, Michael Link, Bob Poston, John Shereikis, Steve Spivey, Faye Taylor, Sharon Jenkins Tucker, Patrick waters

Department Staff: Jill Mays, Danté McKay, Dr. Terri Timberlake

Guest: Lillian Davis, Shelli Keller, Toyia Mather

Welcome and Introductions

Chair Sandye Mullins called the meeting to order and began the meeting with a meditation poem by Mary Oliver called "Journey". Sandye also shared that she will be retiring from the Care and Counseling Center of Georgia at the end of December. This was then followed by introductions by all present at the meeting and a moment of silence.

Respect Institute Graduate: Lillian Davis

Respect Institute speaker Lillian Davis shared her recovery story entitled "My Three Lives". The Respect Institute empowers those in recovery to share their recovery journeys, educating people about mental illness and helping to eliminate stigma.

Review and Approval of Minutes

The Chair Sandye Mullins made a motion to approve the November minutes. Minutes were approved.

Expectations for the next year

The chair of GBHPAC stated that the Council will be receiving reports from the various committees, as well as getting more involved in areas of interest within the state. The committees will be using this time to gather feedback from the community. In addition, utilizing the knowledge gained during GBHPAC spring and summer retreats.

Committee's Report

Cynthia Wainscott, Chair of CYF Committee, spoke about the importance of learning how the Block Grant dollars are spent as a first priority. Danté McKay gave some clarification on how those funds were to be used for children, young adults and families that are channeled through The Department of Education. The next priority that Cynthia spoke about was learning to write a plan for the next two years. Cynthia sought out Jill Mays support with writing the plan. The committee is dedicated to completing this task as it will be beneficial to them. These written priorities will be a guide to the CYF committee on how to spend funds based on the amount available to them at any given time. It will also help them to identify what the top priority is and the necessary funding for that priority. Cynthia is hopeful that the department will also be knowledgeable of other funding streams. $3.8 million in funds that the block grant has been supporting will now be available due to Medicaid coverage of the System of Care Services. Therefore the Council will have some discussions with the department about how the $3.8 million will be spent next year.

Jean Olshefsky, Chair of Adult Committee had the opportunity to meet committee members. The committee will meet every other month. Meeting dates for October and December have already been set. The goals are to discuss priorities, agendas, developing leadership, as well as learning what is covered in the Block Grant. In addition to finding out the exact role of GBHPAC under the block grant. The committee is looking at ways of how they can best support the department, while giving input based on community feedback. Jean thought it would also be nice to have some offshoot committees within the adult committee to support the entire mission of GBHPAC. Moving forward, the adult committee is developing who they are and what their mission is going to be as a subcommittee within the planning council.

Jewell Gooding, who reported for the Advocacy Committee, stated that currently there may be a recount or runoff between Brian Kemp and Stacy Abrams for the governor's seat. Brian Kemp has declared himself the governor and resigned from his former role. There is a special session this week in order to determine what to do with the funds that sits in the governor's budget. If Brian Kemp is declared the governor much of those funds in the governor's budget will be set aside for Kemp to spend for his session. However, if Stacy Abrams is declared the governor there is a likelihood that those funds in the governor's budget will be spent or dramatically reduced and Stacy Abrams would not be able to utilize those funds. Jewell also mentioned that there are 38 new legislators elected. Eleven seats were flipped to the Democrats and three seats went to the Republicans. There will be an upcoming meeting, to orient the new freshman legislators in December. Jewell pointed out that this will be a great opportunity to introduce the freshman legislators to the issues surrounding the behavioral health system. NAMI Georgia and Mental Health America of Georgia will both be present at this meeting to speak to the new legislators.

Jean Toole, Chair of Nominating and membership committee spoke about the committee's effort to revise the orientation manual and the orientation process. The committee reviewed orientation manuals from other States and came up with a list of topics that should be included in GBHPAC orientation manual.

- Council mission and vision
- A copy of the bylaws

- Council history and purpose
- Councilmember expectations
- Member terms, officer terms, attendance policy, committee participation, duties of Council members and officers duties
- List of Council officers with their full terms clearly stated
- Councilmembers with their terms clearly stated
- Council meeting schedule
- The travel reimbursement policy and forms related to it

Additionally, Jean mentioned a resources section where we will have a copy of the planning council 101, links to the Council website, DBHDD's regional map, DBHDD's acronyms and abbreviations, the department's organizational chart, links to GCAL and other websites where individuals can find resources or services.

Action Item: ***If anyone has any ideas or suggestions about what should be in the orientation manual please don't hesitate to contact Jean Toole regarding your input.***

Divisions Updates

Adult Mental Health: Dr. Terri Timberlake

Dr. Timberlake highlighted the Annual Respect in Recovery Walk and its success. There were a number of agencies that celebrated the collaborative efforts. This was a project of the coordinating council transitioning committee. Work is being done to expand the behavioral health crisis centers. Gateway will operate one and the department is in the early stages of awarding a contract to Avita. Dr. Timberlake is proud of the department's compliance in regards to the housing settlement. There has also been tremendous growth over the last seven years in services through the DBHDD. She mentioned that funding is somewhat of a challenge. There has not been a funding increase for CORE services, like basic outpatient services, peers, nurse practitioners etc. It's important for those who can advocate to do so. The department has received additional resources to provide the Georgia Housing Voucher, to those who meet the criteria. *For further information see report embedded below:*

BHPAC Office of Adult Mental Health

Addictive Diseases: Prince Moorman

Prince shared that DBHDD received a few million dollars from the State to fund Recover Support services. These funds were used to support 16 providers in addition to the other 5 recovery support centers that already exist. With the launch of the Recovery support Centers each provider was asked to do a PowerPoint presentation, highlighting their strengths, aspirations, results and expectations. Thereafter, there was a workshop for those 16 providers who started services around September. Nichols Estabrooke was hired as Project Officer to oversee these services. Service guidelines are being

worked on for those providers and how the services will be presented. A systematic approach will be taken. Prince also mentioned there are 9 clubhouses with the capacity to serve 20 youth at each clubhouse. Furthermore, there are over 100 accountability courts across the state. Handouts were given out to share information about the available programs and recovery supports. *For further information see reports embedded below:*


BHPAC Office of Addictive Diseases 1


Office of Addictive Disease handout.pd

Commission's Update: Judy Fitzgerald

Commissioner Fitzgerald, utilized handout to illustrate the transformation story and progress the department has made over the last 10 years. However, there are still several things that are pressing for the department and around the country. The commissioner stated there has been a tremendous investment in outpatient Core services, which may reduce the need for crisis services. Currently, our country is facing an Opiod crisis, which is very dramatic. DBHDD is the state's health authority responsible for providing the funding for community services to address this crisis. The department received 11.8 million over the last two years and 20 million will be allotted for the third year. There has been a lot of training and education that the funds have been used for. Naloxone kits are been utilized and over 900 have been made available and are being used. Grant funding is being used to make Medicated Assisted Treatment (MAT) an option available for those who are uninsured or underinsured. Meth and cocaine usage are back on the rise. Alcoholism, is still the largest driver of addiction challenges in the state of Georgia according to the Commissioner. There is not a plan to build any more mental health beds in our hospitals. The Commissioner spoke of having more information about where the needs currently are. Forensic population is a growing area of interest and concern. This is a priority for DBHDD. Furthermore, the aging population, is an area where more preparation needed. The system is not fully ready for the aging population. The Commissioner expressed making this a priority on her list to work with the aging population and working in collaboration with the Department of Human Services, who serve the aging community. The state has opened up memory assessment centers through Emory University. The State partnered with Emory to allow older adults a place to go when they don't know what is happening with them. It can be anything from dementia to depression and other things they may be dealing with. She also stated the most pressing issue is the workforce shortage in Developmental Disabilities, Mental Health and Addiction and how these shortages are crippling the system. The workforce is stretched to the max in the hospitals, there is a need for more staff in these areas and community based services as well. DBHDD budget has been approved by the DBHDD board and it will be taken to the general assembly. This budget is DBHDD's portion of the Governor's budget. The budget is not official, as of yet. The priorities that are best reflected through the budget are (1) high quality care and the three ways that will be vetted thought the budget request. (2) CORE services is listed. (3)Housing services. (4) Forensic services both in community and hospitals, which is the only area of the hospital which is growing. Annualizations, are not usually a one year funding opportunity and are meant to be ongoing. $18 million is needed to keep it on track. There is an ongoing fund of $15 million for workload adjustments for CORE services. In conclusion, the Commissioner said that there is a 2%

request. Not every agency received the 2% increase. There will be continued investment in crisis bed infrastructure and addictive disease residential beds, which are all community based. Crisis stabilization units were anticipated to serve 70 % psychiatric crisis and 30% detox and addiction. In fact, the opposite happened 70% of the beds are being used for residential addiction and detox and 30% for psychiatric crisis. There is also ongoing commitment for housing voucher. The criteria was written into the settlement agreement and it defines the population that is eligible. There are more residential beds coming for addictive disease. One of the reasons that people stay in crisis beds longer, is because it takes longer for someone to detox the Commissioner noted. *For further information see report embedded below:*

11.13.2018_Georgia Behavioral Health Pl

Office of Federal Grants: Jill Mays

Jill begin by summarizing the report from the Office of Federal Grants for The First Episode of Psychosis. The TTI grant (Transformation Transfer Initiative). Jill mentioned that the decision will be made at the end of the month if the application is approved for $ 150,000. Project LAUNCH is (Linking Actions for Unmet Needs in Children's Health), serve children up to the age of 8 and includes prevention. This is a combined grant with the Department of Public Health. The block grant mini application is still under review and the adjustments have to be made before approval is given. The final allocation was given in October. June is the desired date for the Nominating Committee to have any issues resolved and the fact that GBHPAC doesn't have an appropriate percentage of consumer involvement. This is to satisfy the new changes implemented by SAMSHA. *For further information see report embedded below:*

BHPAC Office of Federal Grant Progr.

Action Item: ***Invite Dr. Druss to speak to the Council at a future meeting about SAMHSA new regional Technical Assistance Center at Emory University***

DBHDD Behavioral Health Budget Manager: Shelli Keller

Shelli shared that DBHDD was awarded $22.7 million for Federal Fiscal year 2018 Block Grant for a two-year term that began October 2017. For Federal Fiscal year 2019 the Block Grant awarded was $22,053,331 which is a reduction from the prior year of $732,478. Each award is a plan of two years, SAMSHA usually gives input as to what they would like to see the funds used for. It was revealed that Peer Support funding has been split 40% state and 60% federal. The service plans from the prior years are always looked at, like Mental Health Courts and other allocations for training as well as Planning Council funding. Shelli stated that additional mental health club houses have been added, First Episode Psychosis earmark requires that DBHDD spend no less than 10% for those service providers. Furthermore, funding will increase for those services and additional providers will be added. The State's spending for children's mental health as of 1984, was no less than $8 million but actually exceeds more than $50 million annually today. *For further information see report embedded below:*

Block Grant Expenditures.pdf

Office of Children, Young Adults and Families (OCYF) Partnership with GSU: Danté McKay

Dante's office received the System of Care Grant worth $11 million over four years for a proposal that was submitted two years ago. In addition to the priorities mentioned by the commissioner earlier, there is also a workgroup led by the division of housing program high utilization management program. This is designed to help understand what the barriers are and why people repetitively cycle through the system. Work is being done collectively and individually in children's services so that the gaps may be closed and services will be rolled out differently than before. Dante mentioned that finding the right pace is important, as opposed to getting things done quickly. Youth Mental Health First Aid training is one of interest. There is a need for enhanced distribution of this training. The Department of Education provided NAMI (National Alliance on Mental Illness), with a grant to provide Youth Mental Health First Aid training. Feeding programs are also needed during the summer time because food costs become excessive. DCAL (Department of Early Care and Learning) and the Department of Education, have a partnership to work with organizations and nonprofit entities to provide the food. Danté spoke about the Mental Health Resiliency Support club and one of the things they offer is, providing nutritious meals for youth and families. *For further information see report embedded below:*

BHPAC Office of Children Young Adu

Office of Recovery Transformation: Mary Shuman

Mary talked about the depth of peer support services and the number of places where Certified Peer Specialist (CPS) work in our system. If the different types of CPSs are taken into account such as CPS parents, CPS youth, CPS AD, CPS whole health. DBHDD have certified over 3300 CPSs to date. In addition, there are nine Medicaid billable services and their services definition require that these nine services be delivered by Certified Peer Specialists. Mary mentioned that there are a lot of other services provided by CPSs and there is often times a misperception of their role in traditional services. The Office of Recovery Transformation is providing education about peers in clinical environment. Developing the peer support workforce is one of the Office of Recovery Transformation main priorities. Another priority, is helping the behavioral health workforce transform their services into a recovery oriented model. Mary explained that her office is in the fifth year of recovery focused training initiative where they are now working with Tier 1 providers. The Office of Recovery Transformation is providing Tier 1 providers a year of coaching, training and technical assistance helping them develop their own recovery focused change teams within their agencies. Mary reports that these providers have done some phenomenal projects with this work that have increased the ability to serve more people and have also made services more enticing. The Office of Recovery Transformation initiative has a recovery orientation evaluation of the system and they were fortunate to be able to participate in Yale Universities' recovery oriented self-assessment survey. Providers were invited to participate in the survey as well. Georgia received one comprehensive report for the state. One of the interesting observations that Mary made was the principal that consumers be involved in all levels of the service system. Example from the Board

of directors all the way down. Interestingly, this principle was the lowest score that Georgia received. Therefore, there is a need to find ways to incorporate people receiving services at all levels of the service system. Another important point was shortages in the workforce, which is surprising because Georgia was considered an innovative State because of using Certified Peer Specialist. *For further information see report embedded below:*

BHPAC Office of Recovery Transforma

New Businesses and Announcements

Sandye spoke about the new member orientation and how they could take a portion of time from the next meeting to orientate the Council in January 2019. Also, whatever is missing from the orientation manual will be discussed. CYF and Adult committees meetings need to be set up to receive support for the funds of $920,000. Jean and Cynthia agreed to set up conference calls with their respective committees.

Meeting Adjourned

GEORGIA BEHAVIORAL HEALTH PLANNING & ADVISORY COUNCIL

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Decatur Rec Center
231 Sycamore St
Decatur, Ga 30033
January 8, 2019
AGENDA

10:00 a.m. **Welcome and Introductions – Sandra Mullins, Chair**
- Moment of Silence
- Respect Institute Graduate – Ernest Brown
- Public Comment

Approval of Minutes for November 2018

10:30 a.m. **Sue Smith & Fam-VOC Survey**

11:00 a.m. **Steve Spivey – Chair of Statewide Leadership**

11:15 a.m. **GDBHDD and Committee Reports – Areas Of Interest, Challenges and Setting Goals**
- CYF committee – *Cynthia Wainscott*
- Adult Behavioral Health Committee – *Jean Olshefsky*
- Adult MH – *Terri Timberlake*
- Addictive Diseases – *Prince Moorman*
- Office of Recovery Transformation – *Tony Sanchez*
- Advocacy Committee – *Jewell Gooding and Neil Campbell*

12:00 p.m. **Working Lunch:** Committees meet

1:00 p.m. **Program – Orientation for all Members- Sandye Mullins**

1:30 p.m. **What are You Proud of and Challenges for the New Year ?**
- Federal Grants Data Reports – Jill Mays
- CYF – *Danté McKay*
- Nominating and Membership Committee – Jean Toole

2:00 p.m. **New Businesses and Announcements**

3:00 p.m. **Meeting Adjournment**

GBHPAC GEORGIA BEHAVIORAL HEALTH PLANNING & ADVISORY COUNCIL

Decatur Rec Center
231 Sycamore St
Meeting Minutes
January 8, 2019

Members Present: Sharon DeMille, Jewell Gooding, Pierluigi Mancini, Sandye Mullins, Jean Olshefsky, Yvette Sangster, John Shereikis, Jean Toole, Cynthia Wainscott, Rebecca Blanton, Sherry Jenkins Tucker, Steve Spivey, Faye Taylor, Patrick Waters, Neil Campbell, Bertrand Brown, Erica Johnson, Tony Sanchez

Members Present by Permanent Alternate: Prince Moorman (for Cassandra Price), Colleen Mousinho (for Keith Bostic), Mary Shuman (for Tony Sanchez), Sarepta Archilla , Linda McCall, (for Brian Dowd), Lisa Pace (for Sue Smith), Harvinder Makkar (PA for John Shereikis)

Members Absent: Eleanor Brown, Mary Davey, Bradley Grover, Ellyn Jeager, Michael Link, Bob Poston, Lucy Hall, Alan Huth, Ron Koon, Amy Kuhns, Thom Snyder, Monica Johnson

Department Staff: Jill Mays, Danté McKay

Guests: Joel Slack, Ernest Brown

Welcome and Introductions

Chair Sandye Mullins called the meeting to order by opening with a moment of silence. Joel Slack then introduced the Respect speaker, Ernest Brown.

Respect Institute Graduate: Ernest Brown

Respect Institute speaker, Ernest Brown, shared his recovery story entitled "Why Me". The Respect Institute empowers those in recovery to share their recovery journeys, educating people about mental illness and helping to eliminate stigma.

Review and Approval of Minutes

November minutes were approved.

Sandye stated that she hopes to have someone from (GCAL), Georgia Crisis and Access Line present at the councils March meeting. Sandye also stated that she is hopeful that once the orientation manual is completely revised, there will be an orientation for all council members.

Family –VOC Survey

Lisa Pace (for Sue Smith) shared information about the Family Voice on Council & Committees (Fam-VOC), which is an assessment for organizational support for family voices. It was developed by FREDLA (Family Run Executive Director Leadership Association, Inc.) and is an online 15 minute, confidential survey. The survey is intended to gauge the extent to which councils, committees and advisory boards support the family voice by engaging and supporting family members to be active and influential. Lisa

asked for the council members to participate in completing the survey. *For further information see reports embedded below:*

Fam-VOC Flyer for Site Coordinators_ C

Fam-VOC Survey_14Jan2019.pc

Steve Spivey – Chair of State Leadership Council

Steve Spivey, Chair of the Statewide Leadership Council, shared information with the council regarding a survey called Identifying Independence and Recovery Needs in Georgia. Steve talked about his experience caring for his 34 year old daughter who lives with special needs. Steve wants to have every person in Georgia complete the survey. The goal is to have 7700 of the surveys completed, so they can be analyzed and turned in to the commissioner. Steve mentioned that the survey was developed by leadership council members and it took 1 year to complete it in entirety. The deadline to have this survey completed is April 15. This survey is also available online and in Spanish. The hope is to eventually have the survey available in several different languages. To date, 1700 surveys have been returned to them but they are in need of more. Steve ended by asking council members complete the surveys via Survey Monkey. *For further information see report embedded below:*

Needs Survey PDF.pdf

Cynthia Wainscott, Chair of the CYF Committee, reported that the committee has set a meeting once a month and are working to develop priorities. Cynthia shared that November was a really exciting time for the CYF committee and in October they found out that there was $400,000 from SAMSHA and the decision had already been made that half of that amount would be for children and half for adults. Cynthia noted that Jill and Dante were helpful with the committee and they have met at least 2-3 times. Cynthia also discussed block grant process and application.

Jean Olshefsky, Chair of Adult Behavioral Health Committee, discussed the October committee meeting which included discussion regarding additional funding and potential uses. The committee decided to go with the recommendation of Dr. Timberlake which was to fund forensic peers and two mental health courts, looking at region 2 and 5 since there are no providers funded to serve the courts in that area. Jean noted that in future meetings the committee would discuss priorities.

Sarepta Archila (for Dr. Timberlake) gave a brief over view of the blended mobile crisis response that was operational as of January 1, 2019. They must arrive within 59 minutes on the site and consult with a medical professional prior to recommending intensive crisis support or behavioral intervention. The clinician must communicate all recommendations within 24 hours to all applicable parties involved and report monthly outcome statements. *For further information see report embedded below:*

BHPAC Office of Adult Mental Health

Prince Moorman (Addictive Diseases) spoke about one of the providers, Lucy Hall (Mary Hall Freedom House) and the challenges they are facing from the City of Sandy Springs. Prince mentioned that the City of Sandy Springs is saying they are not in compliance with city laws. As a result, Lucy Hall is suing the City of Sandy Springs for discrimination. That program has been in Sandy Springs for 22 years and is the only state program in that area for women who have substance abuse disorder and are pregnant or with children. Prince asked if the council could come up with any realistic solutions to advocate and support Lucy. Mary Hall provides outpatient and residential treatment. Prince mentioned that it would be a grave injustice to lose that service. *For further information see report embedded below:*

BHPAC Office of Addictive Diseases 1

Tony Sanchez (Office of Recovery Transformation) spoke about a Faith Based Initiative coming out of the Office of Recovery Transformation. There will be a forum this Saturday at Loudermilk Conference Center, from 9:30 A.M. -12:00 P.M. with more dates in the future.

For further information see report embedded below:

BHPAC Office of Recovery Transforma

Jewell Gooding reported for the Advocacy Committee. Georgia has a new governor elect and the legislative session begins on January 14. Tom Crise, the past HHS (Health and Human Services) secretary will be joining Brian Kemp's team to work on Medicaid waivers. Grady Memorial Hospital is in a pilot project looking at Medicaid waivers and how they have utilized it in the integrated care models. There has been conversation regarding the eliminating of SNAP, Medicaid, and Childcare Subsidies. Advocates are looking at ways to maintain those funding sources to ensure people can have access. Another issue around the state is the certificate of need and the impact on hospitals in rural settings. That is in response to the hospitals, particularly in the rural settings where they do not necessarily meet the eligibility certificate of need. That has put a huge barrier on being able to sustain some of those rural hospitals. Jewell discussed the Healthy Housing Coalition which is supposed to help renters have healthy rental housing conditions and hold landlords accountable for their properties. Mental Health day at the Capital will be on February 8 and is hosted by Behavioral Health Services Coalition.

Neil Campbell announced that Recovery Day is at the capitol next Thursday January 17, 2019 at the Freight Depot from 10:00 A.M-2:00 P.M. Registration is available on the Georgia Council on Substance Abuse's website. Neil also stated there will be SAMSHA discretionary funding coming down for

Recovery Community Organizations and recovery support services in a treatment capacity within the next year.

Jill Mays (Office of Federal Grants) spoke about the Light Program and funding Grady Memorial Hospital and Viewpoint. *For further information see report embedded below:*

BHPAC Office of Federal Grant Progr

2019 BHPAC Mental Health Block Grant

Danté McKay (Office of Children, Young Adults and Families) talked about the block grant and how the block grant is applied. *For further information see report embedded below:*

BHPAC Office of Children Young Adu

Jean Toole (Chair of Nominating and Membership Committee) spoke about the new membership process and orientation manual which will hopefully be ready at our next meeting.

New Businesses and Announcements

Jill mentioned that the Department is making a concerted effort to not use acronyms when they send reports. Faye mentioned that Benchmark, has left region 2. Cynthia encouraged council members to send out those two surveys discussed today.

Meeting Adjourned

GEORGIA BEHAVIORAL HEALTH PLANNING & ADVISORY COUNCIL

GBHPAC vision is "*To be a leading force that strives for an accessible, affordable, comprehensive, and integrated recovery-oriented behavioral health system that cultivates and supports healthy and diverse communities in a culturally and linguistically inclusive manner.*"

GBHPAC mission is "*To bring individuals representing children, adults, peers, and families together to educate, advise, advocate, and monitor the behavioral health system to ensure an effective recovery-oriented system of care.*"

Harris Tower
233 Peachtree St., NE 2nd floor
Atlanta, Ga 30303
March 12, 2019
AGENDA

10:00 a.m. **Welcome and Introductions – Sandra Mullins, Chair**
- Moment of Silence
- Respect Institute Graduate – Mluv Wallace
- Public Comment

Approval of Minutes for January 2019

10:30 a.m. **GCAL Tour and Presentation with Wendy Farmer**

12:00 p.m. **Lunch:** Committees Meet

1:00 p.m. **GDBHDD and Committee Reports – Areas Of Interest, Challenges and Setting Goals**
- Nominating and Membership Committee – *Jean Toole*
- CYF Committee – *Cynthia Wainscott*
- CYF – *Danté McKay*
- Adult Behavioral Health Committee – *Jean Olshefsky*
- Adult MH – *Terri Timberlake*
- Addictive Diseases – *Prince Moorman*
- Office of Recovery Transformation – *Tony Sanchez*
- Advocacy Committee – *Jewell Gooding and Neil Campbell*
- Federal Grants Data Reports – *Jill Mays*

2:15 p.m. **Orientation Manual-Jean Toole**

2:30 p.m. **Recovery Language – Neil Campbell and Sherry Jenkins Tucker**

2:45 p.m. **New Businesses and Announcements**

3:00 p.m. **Meeting Adjournment**

GBHPAC GEORGIA BEHAVIORAL HEALTH PLANNING & ADVISORY COUNCIL

Harris Tower
233 Peachtree St., NE 2nd floor
Meeting Minutes
March 12, 2019

Members Present: Rebecca Blanton, Bertrand Brown, Neil Campbell, Sharon DeMille, Alan Huth, Michael Link, Pierluigi Mancini, Sandye Mullins, Jean Olshefsky, Tony Sanchez, Yvette Sangster, John Shereikis, Sue Smith, Thom Snyder, Jean Toole, Sherry Jenkins Tucker, Cynthia Wainscott, Patrick Waters, Harvinder Makkar

Members Present by Permanent Alternate: Prince Moorman (for Cassandra Price), Colleen Mousinho (for Keith Bostick), Linda McCall (for Brian Dowd), Yosha Dotson (for Jewell Gooding), LaDonna Barnes (for Lucy-Hall Gainer)

Members Absent: Eleanor Brown, Mary Davey, Judy Fitzgerald, Bradley Grover, Ron Koon, Amy Kuhns, Steve Spivey, Faye Taylor, Monica Johnson

Department Staff: Jill Mays, Danté McKay, Dr. Terri Timberlake, Matthew Clay (System of Care Project Director)

Guests: Toyia Mather, Wendy Farmer, Melissa (Mluv) Wallace

Welcome and Introductions

Chair Sandye Mullins called the meeting to order by opening with a moment of silence. The Respect Institute speaker was introduced.

Respect Institute Graduate: Melissa (Mluv) Wallace

Respect Institute speaker, Melissa (Mluv) Wallace, shared her recovery story entitled "Poetry as a Healer". The Respect Institute empowers those in recovery to share their recovery journeys, educating people about mental illness and helping to eliminate stigma.

Review and Approval of Minutes

January Minutes were approved.

Georgia Crisis and Access Line Presentation/ Tour: Wendy Farmer

Wendy shared a brief presentation on Behavioral Health Link prior to taking the council members on a tour of the Georgia Crisis and Access Line (GCAL) call center. GCAL takes on average about 250,000 calls per year. The breakdown of calls that they receive are about 81 % are a primary issue and default issue, 15% are a substance abuse issue and 3% are those who live with a developmental disability, 1.3% of the calls are UTD (unable to determine the primary issue for the call). 75% of their calls are from adults, child and adolescent are about 13% and seniors, over the age of 65, are about 2.76%, unknown are about 9.5%. The calls that GCAL receive are broken down into three categories and they are urgent,

emergent and routine. GCAL recently added texting and chatting as an option for those who may not want to have person to person conversation. The texting and chatting typically takes 45 minutes as opposed to 15 minutes. The app is called "My GCAL" and is available on Itunes and Google. The app has had about 2000 downloads since it began and about 1000 texts and chats. Call center tours were guided by Wendy Farmer and three additional GCAL staff members.

Youth and Families Committee (CYF): Cynthia Wainscott

Cynthia shared information about the committee and the things they had been working on. Cynthia shared that the committee be working on wording they would use in the future to identify their values, things they want to promote and the things that they have championed and the things that will guide them in the future. The list that the Committee has come up with so far is very broad but they are aware that they may not be able to do everything on that list. The committee has committed to having conference calls bi monthly. During the next conference call, the Committee will discuss how they would like to use the extra monies that will be available. The System of Care will primarily use federal dollars. Cynthia mentioned that she is not sure of the exact dollar amount at this time. The committee is devoted to making an impact in the children and families lives that they serve and are making strides in that direction.

DBHDD Children Youth and Families: Danté McKay

Danté shared information about work that has been done in mental health that is relational to children over the last few years. The Governor and Commissioner have received a presentation on "My GCAL" and work related to Autism. The Department of Behavioral Health and Developmental Disabilities (DBHDD) responsibility is to develop and build up crisis services in the continuum of care. Danté introduced Matthew Clay, who is the new full time Project Director for The System of Care expansion grants. Danté shared the information from his report. *For further information see report embedded below:*

BHPAC Office of
Children Young Adu

Chair of Adult Behavioral Health Committee: Jean Olshefsky

Jean shared information from the last meeting of the Adult Behavioral Health Committee. During the meeting Dr. Timberlake went over the Block Grant funding and the different components. The main components discussed were provider training, supportive housing, supported employment, access to services for older adults and criminal justice and mental health. Jean shared that the committee is focusing on coming up with their recommendations before May and that committee will be meeting one more time prior to the May deadline. One of their recommendations will be for expanding funding for mental health courts in various areas. This committee has had robust conversations about identifying and obtaining housing resources and how to retain landlords for the housing for individuals who are in re- entry or coming out of homelessness.

Adult Mental Health: Dr. Terri Timberlake

For further information see report embedded below:

BHPAC Office of
Adult Mental Health

Addictive Diseases: Prince Moorman

Prince shared that one of the providers for addictive disease, is receiving push back from their community. The community is coming at the agency and they are trying to find a way to resolve the issue. *For further information see report embedded below:*

BHPAC Office of
Addictive Diseases 3

Office of Recovery Transformation: Tony Sanchez

Tony shared information about a new initiative called Faith Based and Community Initiative throughout the State of Georgia. That initiative is designed to provide Faith Based organizations with information and skills to support those in recovery. Tony mentioned the upcoming listening sessions that will be held around the state. Tony stated that he has created a recovery policy that came out in January of 2018, which describes the meaning of a recovery oriented system of care. Tony also mentioned that the (CPS) Certified Peer Specialist database has gone live as of March 12, 2019. *For further information see report embedded below:*

BHPAC Office of
Recovery Transforma

Advocacy Committee: Yosha Dotson and Neil Campbell

Yosha discussed a bill for prescription and telemedicine that is currently in the House. She also talked about a School Safe Act that has to do with children. There was much discussion related to House Bill 514, which creates a Georgia Behavioral Health Reform and Innovation Commission.

Office of Federal Grants: Jill Mays

Jill shared that they are on track to talk about priorities and performance measures. These discussions will continue through April. Danté will present a rough proposed plan. Georgia is in the top three and are working with GCAL to make the needed adjustments. *For further information see report embedded below:*

BHPAC Office of
Federal Grant Progr

Nominating and Membership Committee/Orientation Manual: Jean Toole

Jean provided an update on the committees work to update the Orientation Manual. Jean reviewed the manual contents of the manual and asked council members to review and provide feedback. Jean also discussed the committee's thoughts on the orientation process which will involve mentors (current council members) being paired with new council members. The committee is also suggesting that the orientation take place an hour before the new members first council meeting. The committee also thinks it is time to update the council's logo and invited council members to make suggestions.

Recovery Language: Sherry Jenkins Tucker and Neil Campbell

Neil and Sherry discussed recovery oriented language and gave examples of things that could be viewed as offensive or hurtful to others. Neil also mentioned the different trainings that are offered on cultural competency. Sherry encouraged council members to use language that is person centered and identifies the person first as opposed to identifying the person as their challenge.

New Businesses and Announcements

Jill mentioned that Georgia was awarded a technology transfer grant to enhance the crisis bed board capacity. The enhancement will create quicker access to individuals waiting for crisis beds.

Meeting Adjourned

GEORGIA BEHAVIORAL HEALTH PLANNING & ADVISORY COUNCIL

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GBHPAC mission is "*To bring individuals representing children, adults, peers, and families together to educate, advise, advocate, and monitor the behavioral health system to ensure an effective recovery-oriented system of care.*"

Chatham Savannah Authority
761 Wheaton St,. Rm 1009C
Savannah, Ga 31401
May 14, 2019
AGENDA

10:00 a.m. **Welcome and Introductions – Pierluigi Mancini, Chair Elect**

- Moment of Silence
- Respect Institute Graduate – Wendy Eugene
- Public Comment

Approval of Minutes for May 2019

9:30 a.m. **Presentation on PATH Program with Carlos Baker**

10:30 a.m. **Tour "Cove at Dundee" Tiny Houses**

12:00 p.m. **Lunch:** Committees Meet

1:00 p.m. **DBHDD and Committee Reports – Areas Of Interest, Challenges and Setting Goals**

- Nominating and Membership Committee – *Jean Toole*
- CYF Committee – *Cynthia Wainscott*
- CYF- *Danté McKay*
- Adult Behavioral Health Committee – *Jean Olshefsky*
- Adult MH- *Terri Timberlake*
- Addictive Diseases – *Prince Moorman*
- Office of Recovery Transformation – *Tony Sanchez*
- Advocacy Committee – *Jewell Gooding*
- Office of Federal Grants and CLC – *Jill Mays*

1:45 p.m. **New Business and Announcements**

2:00 p.m. **Meeting Adjournment**

GBHPAC GEORGIA BEHAVIORAL HEALTH PLANNING & ADVISORY COUNCIL

Chatham-Savannah Authority
761 Wheaton St, .Rm 1009C
Savannah, Ga.
Meeting Minutes
May 14, 2019

Members Present: Bertrand Brown, Sharon DeMille, Alan Huth, Amy Kuhns, Pierluigi Mancini, Jean Olshefsky, Tony Sanchez, Yvette Sangster, John Shereikis, Sue Smith, Faye Taylor, Jean Toole, Sherry Jenkins Tucker, Cynthia Wainscott, Patrick Waters

Members Present by Permanent Alternate: Prince Moorman (for Cassandra Price), Yosha Dotson (for Jewell Gooding)

Members Absent: Rebecca Blanton, Keith Bostick, Brian Dowd, Lucy- Hall Gainer, Neil Campbell, Judy Fitzgerald, Ron Koon, Michael Link, Sandye Mullins, Thom Snyder, Steve Spivey, Monica Johnson, Linda McCall,

Department Staff: Jill Mays, Danté McKay, Dr. Terri Timberlake, Kelly Sterling

Guests: Wendy Eugene, Carlos Baker, Ladji Ruffin, Nicole Fields, Ronnie Flournoy, Chris Johnson, Katie Patterson

Welcome and Introductions

Chair Elect Pierluigi Mancini called the meeting to order by opening with a moment of silence. Pierluigi, thanked Mr. Baker and The Chatham-Savannah Authority for the Homeless for hosting the meeting in Savannah. Pierluigi spoke about the loss of Ted Johnson and remembering him during the moment of silence. Following introductions, Pierluigi mentioned the "public comment" section of the agenda and inviting the public to future to give comments, concerns etc. Pierluigi is hopeful that the council will hear more from the community in the future.

Respect Institute Graduate: Wendy Eugene

Respect Institute speaker, Wendy Eugene, shared her recovery story entitled "Blessed". The Respect Institute empowers those in recovery to share their recovery journeys, educating people about mental illness and helping to eliminate stigma.

Review and Approval of Minutes

March minutes were approved.

Chatham- Savannah PATH Presentation/ Tour: Carlos Baker

Mr. Baker gave a presentation on the Region 5 PATH team, which is comprised of five individuals. The Chatham-Savannah PATH team is unique because it is a part of the local continuum of care. The PATH team has several programs which include, permanent housing options, a program called "City 60";

which is a permanent housing unit where individuals can obtain a housing voucher, five emergency shelters for men, two primary emergency shelters for women, to include two other emergency shelters and transitional programs for women and children and a feeding site. The PATH team is comprised of Peer Specialist that have their own lived experience with homelessness and the support of the continuum of care services. The PATH team has been providing services for over 15 years and has had an opportunity to build a rapport with the community over those years. One of the challenges the PATH team faces, is receiving certain crisis services in the community and having affordable and safe permanent housing options in the community. There is a unified referral process, through Department of Behavioral Health and Developmental Disabilities (DBHDD) which is advantageous for those individuals because it provides an extra layer of care. It allows for short term linkages and access to more housing options. The Cove at Dundee is a grass roots program, that has taken four years to get up and going. It is an alternative housing option for veterans. There is currently no one living on the property but that will change this summer. Region 5 PATH team has actively 131 individuals enrolled in the local continuum of care can interact with 231 individuals that are unsheltered. The PATH team interfaces with the four accountability courts which includes drug court, mental health court, family independency court and veteran's court. The PATH team, also interacts with and support individuals from Georgia Regional Hospital. The PATH team goes to meet with an individual at the hospital and enroll them in services, which includes the unified referral services and higher level of care as needed. After the presentation Council Members were led on a tour at "The Cove at Dundee" for homeless individuals who are veterans.

Jean Toole –Nominating and Membership Committee

Jean updated the council on the progress on the New Member Orientation Manual as well as a new logo for the council. The projected date for the finalization of the manual is the next council meeting in July. Jean mentioned the expiration of some council's memberships in September and what categories would need to be filled in that process. Jean noted that a survey will be created to identify other categories that members might possibly be able to fill. Members will be asked to check all areas that apply to them in the survey. Jean also mentioned she will send out information regarding votes for a chair elect nominations.

Youth and Families Committee (CYF): Cynthia Wainscott

Cynthia shared an update on the work that the CYF committee has done between council meetings. This included working on projects to use the extra block grant monies left over. The CYF Committee has worked on values, principles and priorities. Cynthia mentioned that The Department of Behavioral Health and Developmental Disabilities (DBHDD) will make the final decision on how the money should be spent. The other things that are in the Federal Law states that the CYF committee monitor, evaluate and advocate for those services. The reason the CYF is working on principles is to help guide them with consistency. Prevention and early intervention are two of the priorities the CYF committee has set. The planning for the block grant application is on schedule to finalize the spend plans by the end of August.

DBHDD Children Youth and Families: Danté McKay

Danté shared and explained the financial spend report and the Commission on Children's Mental Health. Sue Smith and Danté met to outline the things that need to happen in order to get the ball rolling on the street outreach pilot and having Certified Peer Specialist in the emergency room. The Department of

Family and Children Services has a great interest in the street outreach pilot. The next steps in the program would be to have a meeting with Colleen Moushino, Sue Smith and Danté McKay to formalize the deliverables. Danté shared that there were 13 awards to extend the APEX Program. There were 30 proposals in totality for the funding. The department will hire a fiscal intermediary to support them with the process. *For further information see report embedded below:*

BHPAC Office of Children Young Adu

CYFMH_PROPOSED

MHBG_FY20

Chair of Adult Behavioral Health Committee: Jean Olshefsky

Jean shared about the plan to schedule a meeting with the Children, Youth and Families and Adult Behavioral Health Committees to identify and discuss the Key Performance Indicators. Jean shared her desire to have the recommendations ready by being proactive in making recommendations and working with the department. Jean informed the council that there will be a Doodle Poll sent to CYF Committee members for a meeting soon.

Adult Mental Health: Dr. Terri Timberlake

Dr. Timberlake asked for feedback and suggestions from the council members about the draft DBHDD vision statement. Dr. Timberlake shared that The Department is working on closing gaps in care for those individuals that receive the care. There has been one change that has been made to the proposed block grant spend plan, which is that 40 supported employment slots for Douglas County have been added. *For further information see report embedded below:*

BHPAC Office of Adult Mental Health

Proposed Revised Vision Statement.pc

AMH_PROPOSED SP

MHBG_FY20

Addictive Diseases: Prince Moorman

Prince shared an update on the Opioid treatment epidemic. The grant monies given to addictive disease two years ago has expired. The left over funding has been kept and extended for a third year. The money was used to add additional providers for treatment, which gives more options for individuals to choose from. More information will be shared as data is collected from the grant with outcomes. The data will be collected by the epidemiologist that has been added to their staff. *For further information see report embedded below:*

BHPAC Office of Addictive Diseases 5

Office of Recovery Transformation: Tony Sanchez

Tony shared about the good work that has been done in the peer workforce. The Georgia Mental Health Consumer Network, along with Appalachian Consulting, in partnership with Department of Behavioral Health and Developmental Disabilities traveled around the state to hold listening sessions. *For further information see report embedded below:*

BHPAC Office of Recovery Transforma

Advocacy Committee: Yosha Dotson

Yosha discussed Policy Update Governor Kemp signed the Behavioral Health Commission bill (HB514). Appointments are expected within the next few weeks. SB106 (Waiver bill) was also signed and the Governor's office is expected to select one of 6 agencies to make help create the 1115 and 1332 waiver to submit to the federal govt.

Office of Federal Grants: Jill Mays

Jill shared that Atlanta has been selected to host the 2020 ISPS-US (International Society for Psychosocial Approaches to Psychosis) conference. ISPS is a recovery-oriented organization that provides a forum for individuals, families, practitioners, peer support providers, students, and researchers seeking to improve conditions and care for people with mental health challenges. Jill will send additional information as plans develop.

The state Project LAUNCH group has identified a sustainability plan that will be officially announced in late May 2019, more information will be shared after the announcement.

GBHPAC committees are on track with completing tasks for the upcoming MHBG application (i.e. spend plan recommendations and review and development of performance measures). Still to be completed are the Memorandum of Understanding (MOU) between the BHPAC and GMHCN, which will clearly outline the financial agreement. This document would become part of the GMHCN FY20 contract. Since this item has was not completed in time to get a good spending analysis, funding for the BHPAC will have to remain level in the FY 2020/2021 MHBG application.

DBHDD is in the process of applying for SAMHSA's Transforming Lives Through Supported Employment grant. The **S**upported **E**mployme**N**t for **D**iverse **P**opulations (SENDuP) Project will focus on two underserved areas (north central and southwest Georgia) and three underserved populations, i.e. Older Adults (65 and over), Veterans, and American Indians. The project will expand IPS Supported Employment services to an additional 400 individuals (80 annually) over the next 5 years.

For further information see report embedded below:

BHPAC Office of
Federal Grant Progr.

New Businesses and Announcements

Jill mentioned that Georgia was awarded a technology transfer grant to enhance the crisis bed board capacity. The enhancement will create quicker access to individuals waiting for crisis beds.

Meeting Adjourned

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2020 End Year: 2021

Type of Membership	Number	Percentage of Total Membership
Total Membership	**35**	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	3	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	3	
Parents of children with SED/SUD*	1	
Vacancies (Individuals and Family Members)	2	
Others (Advocates who are not State employees or providers)	7	
Persons in recovery from or providing treatment for or advocating for SUD services	3	
Representatives from Federally Recognized Tribes	0	
Total Individuals in Recovery, Family Members & Others	**19**	**54.29%**
State Employees	12	
Providers	2	
Vacancies	2	
Total State Employees & Providers	**16**	**45.71%**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	9	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	2	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**11**	
Youth/adolescent representative (or member from an organization serving young people)	1	

* States are encouraged to select these representatives from state Family/Consumer organizations or include individuals with substance misuse prevention, SUD treatment, and recovery expertise in their Councils.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Vacancies:

Two (2) Individuals and Family Members
1. Person In Recovery-Young Adult (Mental Health)
2. Parent of Youth in Recovery (Addictive Disease)

Two (2) State Employees & Providers
1. Provider of Children, Youth and Families Services
2. State Board of Pardons and Paroles

Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

   a) Public meetings or hearings? ☐ Yes ☐ No

   b) Posting of the plan on the web for public comment? ☐ Yes ☐ No

   If yes, provide URL:

   https://dbhdd.georgia.gov/mental-health-block-grant-2020-2021-application-review

   c) Other (e.g. public service announcements, print media) ☐ Yes ☐ No

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Public hearing announcement:

https://classifieds.ajc.com/ads/public-notices/legal-public-hearing/legal-notice-notice-of-public-hearing-in-accordance-500923